1-1-2005

Exploring the subjective meanings and experiences of depression

Reena Sheth
Eastern Illinois University

THESIS REPRODUCTION CERTIFICATE

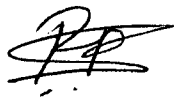
TO: Graduate Degree Candidates (who have written formal theses)

SUBJECT: Permission to Reproduce Theses

The University Library is receiving a number of request from other institutions asking permission to reproduce dissertations for inclusion in their library holdings. Although no copyright laws are involved, we feel that professional courtesy demands that permission be obtained from the author before we allow these to be copied.

PLEASE SIGN ONE OF THE FOLLOWING STATEMENTS:

Booth Library of Eastern Illinois University has my permission to lend my thesis to a reputable college or university for the purpose of copying it for inclusion in that institution's library or research holdings.



08/11/05

Author's Signature Date

I respectfully request Booth Library of Eastern Illinois University **NOT** allow my thesis to be reproduced because:

_____

_____

_____

_____ _____

Author's Signature Date

This form must be submitted in duplicate.

Exploring the Subjective Meanings and Experiences of Depression

BY

Reena Sheth

THESIS

SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIRMENT FOR THE DEGREE OF

Masters of Arts in Clinical Psychology

IN THE GRADUATE SCHOOL, EASTERN ILLINOIS UNIVERSITY
CHARLESTON, ILLINOIS

2005
YEAR

I HEARBY RECOMMEND THIS THESIS BE ACCEPTED AS FULFILLING THIS PART OF THE GRADUATE DEGREE CITED ABOVE

8/11/2005
Date

Thesis Director

8/11/05
Date

Department/School Head

Exploring the Subjective Meanings and Experiences of Depression

Thesis for a Master's Degree

In Clinical Psychology

Eastern Illinois University

Charleston, Illinois

Reena Sheth

Chair: Ronan S. Bernas, Ph.D.

Anupama Sharma, Ph. D.

Marjorie Hanft-Martone, M.A.

Abstract

This study aimed to provide subjectivist accounts of how people understand and interpret their experience of depression. In the mainstream research on depression, the voices of people who experience depression are largely absent. Therefore, the meanings and experiences of depression from the perspective of people who are living with depression themselves were explored in this study by drawing on in-depth interviews. The stories of two participants diagnosed with depression were examined using the holistic-content and the holistic-form analysis approach proposed by Lieblich, Mashiach, and Ziber (1998). Illness narrative forms outlined by Frank (1998) were also utilized to explore how the participants constructed their stories of depression. Different ways in which people make sense of experiencing a mental illness like depression were highlighted and were contrasted with objectivist accounts of depression.

The narrative approach of the present study provided the participants with an opportunity to gain a voice and to present their own stories. Their stories revealed experiences of depression that were dynamic, constantly evolving, multidimensional and holistic in nature. The participants used individual, social, and cultural sources to make sense of their experience of depression. They used metaphors to convey the overarching suffering central to an illness like depression. In their stories, the participants constantly evaluated their identity, an integral part of the experience of a mental illness like depression. When all the personal details of the participants' depression experience were taken into account, depression became a multi-faceted experience that is embedded in relationships and social settings and not just within an individual experience of pathology.

Dedication

I dedicate this thesis to my family: my father Pramod Sheth, my mother Jayshree Sheth, and my brother, Jignesh. I say thank you for your immense love, warmth, and confidence in me. You have been and always will be my first and most important sources of inspiration. I also thank you for all your prayers and good wishes for me to succeed in whatever endeavors I undertake.

Acknowledgements

First, I would like to thank Lord Ganesh, lord of the good beginnings, for his blessings to start and complete this thesis without any obstacles. I also give thanks to Lord Parshvnath and Lord Mahavirswami for gracing me with the ability to pursue knowledge in all its glory.

I would like to express my gratitude to 'Donna' and 'Tony' who participated in this project and allowed me to witness their most intimate stories. They have taught me so much. I thank my thesis committee chair, Dr. Ronan Bernas, for excellent advice throughout the process of writing this thesis. Dr. Bernas, I would have never taken up or completed this thesis without your constant encouragement and support. Under your guidance, I have acquired invaluable insights about paying attention to detail, thinking logically yet creatively, and being patient.

I also thank my other thesis committee members, Dr. Anupama Sharma and Marjorie Hanft-Martone for being patient with me while I trudged along this project. Your encouragement and valuable input during the course of this project were very useful and made it easier for me to complete it. I am especially grateful for your continual confidence in me throughout my entire stay at Eastern. Finally, I would like to thank Dr. Gloria Leitschuh who was very generous in providing me with the participants for this project.

Table of Contents

Exploring the Subjective Meanings and Experiences of Depression

This study aims to provide subjectivist accounts of how people understand and interpret their experience of depression. Specifically, it will explore the meanings and experiences of depression from the perspective of people who are living with depression themselves. Drawing on in-depth interviews with people suffering from depression, this study will highlight the sense-making processes of depression and contrast it with objectivist accounts of depression.

Under the label of 'melancholia', depression has been one of the oldest known mental disorders. It is mentioned in the Old Testament as well as by Hippocrates (Kangas, 2001). Depression has been identified as one of the most prevalent of all psychiatric disorders. Recent estimates indicate that almost 20% of the U.S. population, primarily women, will experience a clinically significant episode of depression at some point in their lives. In fact, the rates of depression are so high that the World Health Organization Global Burden of Disease Study ranked depression as the single most burdensome disease in the world in terms of total disability-adjusted life years among people in the middle years of life (Gotlib & Hammen, 2002).

Within mainstream psychological research, depression is conceived of as a clinical problem present within the individual. It is objectively defined in symptom-based diagnostic classification systems such as the International Statistical Classification of Diseases and Related Health Problems (ICD-10, World Health Organization, 1992) and the Diagnostic and Statistical Manual OF Mental Disorders (DSM-IV-TR, 1994). The DSM-IV-TR classifies mood disorders into Depressive Disorders (Major Depressive

Disorder), Bipolar Depression, Depression due to a General Medical Condition, and Substance-Induced Mood Disorder. The current study will examine Major Depressive Disorder (MDD) which is defined by the DSM-IV-TR as a mood state, a symptom, and a syndrome consisting of a set of symptoms. It characterizes MDD as a constellation of emotional (sadness and anhedonia), cognitive (worthlessness or guilt, difficulty concentrating, and suicidal ideation), behavioral (notable difficulty in social, familial, and occupational areas of life), and physical (sleep difficulties, appetite or weight changes, psychomotor changes, fatigue) symptoms.

Objectivist Accounts of Depression

Research on depression has been conducted by investigators from various disciplinary backgrounds. Clinical psychologists, for instance, have carried out research to test hypotheses derived from psychosocial models. Social models of depression have been explored by researchers whose disciplinary affiliation is with sociology or social psychology (Stoppard, 2000). Such research is usually conducted using a plethora of highly structured, sophisticated, and state-of-the art procedures and instruments such as the Diagnostic Interview Schedule-IV (DIS-IV; Bucholz, et al., 1999, as cited in Gotlib & Hammen, 2002), The Structured Clinical Interview for DSM-IV Axis I disorders (SCID-I; First, Spitzer, Gibon, & Williams, 1997), The Hamilton Rating Scale for Depression (HRSD; Hamilton, 1960), The Beck Depression Inventory-II (BDI-II; Beck, Steer, and Brown, 1996), and many other similar clinician-rated or self-report measures. On the other hand, medically trained investigators have carried out research to test biological models of depression. Investigators in search of neuroanatomical causes have utilized physiological apparatuses such as Magnetic Resonance Imaging (MRI),

Electroencephalograms (EEG), and Positron Emission Tomography scans (PET scans), while those focused on the genetic make-up of individuals who suffer from depression have conducted twin and family studies. Despite the wide range of disciplinary fields represented among researchers whose work has focused on depression, certain homogeneity is apparent in the research methodologies employed (Stoppard, 2000). The methodological commonalities shared by these research approaches are captured by the term "the scientific method" (also sometimes labeled "mainstream" or "objectivist").

Modes of Achieving Objectivity in Studying Depression

A paramount methodological requirement of "the scientific method" is "*objectivity*", something which in part is accomplished by use of "objective" forms of measurement, so as to rule out the influence of the researcher on any results obtained. This is achieved through: a) objectively defining the psychological phenomenon being studied; b) creating standardized measures; and c) excluding the social and cultural contexts of the phenomenon.

Objectively defining depression. In mainstream approaches to research on depression, an issue that must be addressed before any information, or "data", can be collected is how depression will be defined and measured. In the vast majority of such studies, the issue has been resolved by defining and measuring depression in terms of specifying a set of criteria to diagnose depressive disorder (as MDD defined by DSM-IV-TR) and measuring depressive symptoms through clinician and/or self-rated questionnaires like the BDI-II. According to Stoppard (2002), use of standard ways of defining and measuring depression, which have wide agreement among researchers, is

recognized as a prerequisite for attaining objectivity (p.14). In the DSM, a mental disorder is defined as follows:

> [E]ach of the mental disorders is conceptualized as a clinically significant behavioral or psychological *syndrome* or pattern that occurs *in an individual* and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. In addition, this *syndrome* or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example, the death of a loved one. Whatever its original causes, it must currently be considered a manifestation of a behavioral, psychological, or biological *dysfunction in the individual*. Neither deviant behavior (e.g., political, religious, or sexual) nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a *symptom* of dysfunction *in the individual*, as described above (emphases added; American Psychological Association, 1994, p. xxi-xxii).

According to this definition, a mental disorder, along with its causes, is something which resides within the individual. This results in a 'reification' of the notion of mental disorder. The term "reification" refers to a way of thinking in which concepts (such as mental disorder) are treated as labels for real entities that are presumed to have a material existence independent of the terms used to denote them (Stoppard, 2000). In the case of the DSM, this reification is fostered by the assumption that mental disorders lie within

individuals, implying that physiological processes within the body are involved. This way of conceptualizing mental disorders has obvious parallels with medical definitions of diseases, conditions affecting the biological body (Stoppard, 2000).

In the vast current scientific literature on depression, one of the standard (or objective) means of defining depression is the diagnostic criterion of depression found in the DSM-IV-TR. This diagnostic set of criteria consists of a list of subjective and bodily experiences. According to the DSM-IV-TR (APA, 1994), these symptoms must be "present during the same two-week period" and must "represent a change from previous functioning" to make a diagnosis of depression. These symptoms include:

A. Presence of five or more of:

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful).
2. Markedly diminished interest or pleasure in all, or almost all activities most of the day, nearly every day.
3. Significant weight loss when not dieting or weight gain, or decrease or increase in appetite nearly every day.
4. Insomnia or hypersomnia nearly everyday.
5. Psychomotor agitation or retardation nearly every day.
6. Fatigue or loss of energy nearly every day.
7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day.

8. Diminished ability to think or concentrate, or indecisiveness, nearly every day.
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or suicide attempt or a specific plan for committing suicide.

B. The symptoms do not meet the criteria for a Mixed Episode.

C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

E. The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation (DSM-IV-TR, 1994, p. 327).

Several observations can be made about the format and content of the diagnostic criteria for depressive disorder given in DSM. First, the criteria are formatted in a precise way, with clear directions for diagnostic decision-making (e.g., "Five [or more] of the following symptoms have been present"). Second, the form in which the criteria are presented, and their impersonal phrasing (there is no mention of the person being assessed), help to create an impression of detached scientific objectivity. The message that seems to be implied by this format is that the criteria have been established through impartial inquiry by those with expertise in the field of depression. Thirdly, the

presentation of criteria as a numbered list and the specification of an exact number of criteria required for diagnosis enhance the impression of scientific rigor (Stoppard, 2000).

Several observations can also be made about the content of the criteria itself. First, the criteria include terms (e.g. "insomnia or hypersomnia", "psychomotor agitation or retardation") unlikely to be familiar to people without medical training. Second, lack of attention to the social context forming the background to the experiences of depressive disorder is also an inherent aspect of the diagnostic criteria for depressive disorder (Stoppard, 2000). Thus, the criteria focus primarily on an individual's subjective and bodily experiences.

In terms of diagnosis, the disorder is presumed to be either present or absent. That is, a person either does or does not have the disorder of depression. From this diagnostic perspective, to say that a person's problem is depression is analogous to the situation in which a person is diagnosed with a medical disorder such as diabetes or cancer (Stoppard, 2000). Individuals diagnosed with a mental disorder such as depression are then considered to be patients within the medical domain. As a consequence of their contact with professionals, either mental health experts or researchers, experiences of depression become medicalized and viewed as signs of internal, individual problems, or "psychopathology" (Oakley, 1986; Russell, 1995, Ussher, 1991, as cited in Stoppard, 2000).

The DSM framework has been adopted by mental health professionals and researchers around the world and is considered to be an important tool in the scientific study of mental disorders and in particular, for research on depression (Stoppard, 2000), resulting in the formulation of experience of depression as a 'disease' or a 'disorder'. A

large number of studies aiming to provide either epidemiological, genetic, or psychosocial explanations of depression employ the DSM diagnostic criteria to assign subjects to experimental (people with depression) and control groups (people without depression) (e.g., Weissman, Bruce, Leaf, Florio, & Holzer, 1991; Kendler, Neale, Kessler, Heath, & Eaves, 1993).

In sum, when the diagnostic criteria for depression is used to meet the criteria of objectivity, depression becomes a disease situated within the individual which has a reality of its own in the world, separate from not only the individual who experiences it but also the researcher who aims to understand or explain it.

Using standardized measures of depression. Another important means of achieving objectivity in the mainstream research on depression is the use of statistically reliable and valid questionnaires that are either self or clinician (researcher) administered. These questionnaires measure specific personality dimensions or traits like neuroticism, extroversion, sociotropic (relational or interpersonal) personality, or autonomous (achievement oriented) personality, negative life events, and severity of depressive symptoms. Frequent use of these questionnaires is found mainly in etiological studies of depression that aim to identify some of the causal factors or processes that lead to development of depression. Two of the most frequently used and popular questionnaires that measure the severity of depressive symptoms are the Hamilton Rating Scale for Depression (HRSD, Hamilton, 1960) and the Beck Depression Inventory-II (BDI-II, Beck, Steer, & Brown,1996). Both of these questionnaires are based on the DSM-IV-TR criteria for depression and some of the items included are: "I am sad all the time", "I do not expect things to work out for me", "I expect to be punished", "I am more irritable

than usual", and "I sleep and/or eat somewhat less/more than usual" etc. (BDI-II, Beck, Steer, and Brown, 1996).

Although these questionnaires fulfill the criteria of objectivity, they have several consequences that restrict possibilities for understanding individual, subjective experiences of depression. According to Stoppard (2000), the creation and employment of questionnaires essentially reduce and constrain the individual's experience to fit the items it contains. Experiences lying outside the range of items included on a questionnaire essentially are deemed irrelevant and remain unexplored (p. 19). Frank (1997) has adapted the concept of 'interpellation' proposed by Louise Althusser (1984) to describe this process. According to him, to interpellate a term is to fit into a slot that is already there, waiting to be filled. The term put into this slot then is understood as always-having-been the sort of term that fits that slot. Rather than the slot having been waiting for the term to fill it, the term was waiting for the slot to give it its proper place, or definition, or self-understanding (p. 33). Questionnaires interpellate people's experiences of depression into slots, making them believe that they are the sorts of people—the sorts of *subjects*—these slots require. For example, questionnaires achieve interpellation by determining a person's attitudes, beliefs, or attributional styles as 'dependent' or 'dysfunctional' whereas items on questionnaires like BDI-II merely imitate the diagnostic criteria of DSM without any attention to rich description and qualitatively different ways in which people experience emotions like sadness, lack of pleasure, and feelings of guilt. Everything is reduced to categories or slots of sadness, pessimism, past failure, loss of pleasure, self-dislike or agitation into which an individual's experiences are artificially fitted.

Most critically, people's accounts of their subjective experiences are not treated as having validity in their own right when subjected to standardized questionnaires. Instead, after being transformed into responses on standardized questionnaire items, people's reports of their experiences are reinterpreted by researchers as signifying their standing on various personality dimensions, exposure to negative life events, or severity of depressive symptoms. The result is that a person's accounts are treated as a source for evaluating the validity of the researchers' constructions, rather than having meaning in their own right (Stoppard, 2000).

Exclusion and neglect of social contexts. In the mainstream objectivist studies of depression that typically aim to explain the etiology of depression, the causal or predictive relationships are established by manipulating or measuring changes in one variable and observing the effect or corresponding changes in another. For example, the availability of amount of social support at different times in an individual's life is measured and correlated with the presence or absence of depressive symptoms. This method of objectively testing 'hypotheses' results in further reduction of the experience of depression into fragmented parts, which in turn are treated as being separate and apart from the sociocultural context of an individual's life. The experience of depression becomes an entity that is fixed in time as opposed to an experience that continually evolves as the person experiencing it interacts with other social, economic, political, and cultural aspects of her or his life.

Though there are existing social models of depression, they still adopt a reductionist methodology and conceptualization. Even though the 'social context' of an individual forms the core of the scientific explanation, it is defined in very narrow terms

to adhere to the 'objective' criteria of objectivist methodology of data collection. According to Stoppard (2002), the social environment in mainstream social models of depression is conceptualized primarily in terms of life events, particularly events involving forms of personal misfortune. Included as misfortunes are events which would be expected to have a fairly direct and generally negative impact upon an individual. Examples of adverse events include ill-health, or disability, the serious illness or death of a spouse or close relative, loss of employment, breakdown of marriage. When events such as these happen, they often are accompanied by consequences which have deleterious effects upon the quality of a person's everyday life (p. 84).

Stoppard (2000) argues that in considering how the circumstances of an individual's life might be implicated in depression, social models still remain focused at the level of individual lives (p. 85). Political and economic conditions shaping an individual's life are excluded from consideration. The finding that women caring for young children on a full-time basis are particularly vulnerable to depression is explained in terms of the stressful circumstances of such women's lives, conditions made more stressful when a negative event (e.g. unemployment, a child's illness) is also experienced. The issue of why childcare is primarily a woman's responsibility and why women caring for young children receive so little public recognition and are not addressed by social models of depression (Stoppard, 2000). Thus, some of the crucial structural conditions that form part of the experience of depression are ignored in these explanations.

Highlighting the detachment and judgments of researchers. The exclusive focus on unearthing underlying causal relationships in order to predict and control depression highlights the judgment and detachment of the researchers. The requirement of a large

number of "subjects" results in the aggregation of the uniquely different experience of depression of each individual. Frank (1992) argues that aggregation that takes place through such data collection methods tries to make sense of individual experience by contextualizing it within macro structures. He defines macro structures as functionally-driven subsystems. They are complexes of organizations that are 'driven' by the demands of their own functioning, not by the needs of the people who serve them. In the case of depression, examples of functionally driven subsystems include hospitals, mental health clinics, and government or APA supported agencies that fund the research on depression. A vast amount of studies on depression are sponsored by the National Institute of Mental Health (NIMH, example of studies are National Comorbodity Survey, Epidemiological Catchment Area studies etc.) and the World Health Organization (WHO). These systems require that experience be categorized as data, not reciprocated as shared vulnerability. The organization of these systems is necessarily opaque from the perspective of the single individual (Frank, 1992).

Ignoring experiences of 'suffering'. Another important casualty of this aim of prediction and control is the concept of 'suffering' itself. In majority of studies, suffering becomes an unverifiable premise that may underlie an observable response, and that the response is what counts and is measured in innumerable questionnaires (Frank, 1992). For example, Munoz, Huynh-Nhu, Clarke, and Jaycox (2002) suggest some essential steps for carrying out reliable prevention research on depression. These steps include utilization of elaborate intervention protocols, detailed description of information being conveyed to the participants, random assignments of participants, and the use of control or comparison groups to measure the effectiveness of the intervention.

The wording and format of the above mentioned suggestions adequately highlight the top-down process of controlling (in this case through prevention) the 'target condition' of depression. In the definitions of content and process, the underlying assumption is that the researchers or clinicians are the professionals properly equipped to 'deliver' preventive care. Similarly, the process of aggregation mentioned by Frank (1992), which completely neglects the individual suffering inherent in depression is also highlighted in these suggestions where the focus is solely on the 'delivery of information' and objectively measuring the effects of the intervention rather than establishing a relationship and environment where the individual experiencing depression is given an opportunity to present her or his suffering, and not just the symptoms of depression. Emphasis is on utilization of information protocols, instruments, dividing and classifying people into groups, and measurement of 'optimal treatment adherence' as opposed to asking individuals themselves about their experience of accepting and undergoing a particular treatment of depression. Similar views are echoed in the following remarks by Karp (1996), who suffered from depression:

> "When I try to examine the hostility part of my response to medication, I realize how deeply my feelings about drugs are tied up with my views about psychiatry and its prevailing definition of depression as a biological disease. A medical treatment focused exclusively on changing patients (either changing the person's self through talk or their biochemistry with pills) leaves wholly unattended the structural sources of human pain. As such, most psychiatric treatment is inherently conservative by implicitly supporting the systemic status quo. Medicine nearly always interprets

> illness as a reflection of individual physical pathology and rarely as a normal response to pathological social structures. Following this line of thinking, I find the current medical rhetoric that hypes medication as the cure for depression to be both scientifically arrogant and politically retrograde." (p. 79-80).

Value and Significance of an Objectivist Approach to Depression

A vast traditional, objectivist approach to studying depression certainly has value and significance. It has contributed to the formulation of theoretical concepts. A number of theories have implicated various forms of biological processes like deficiencies in neurotransmitters, sleep disturbance, irregulation in the functioning of the thyroid gland, etc. in explaining the etiology and course of depression.

Epidemiological research on depression has also resulted in insights about the prevalence, comorbidity, onset, course, and public health interventions for depression. Twin and adoption studies in both community and clinical samples have demonstrated that genetic and nonshared environmental factors each contribute to the risk for depression. Likewise, it has been able to delineate the specific cognitive deficits and biases that characterize the depressed persons and it has examined the role of impaired interpersonal functioning in the development of depression.

The results of these studies have been responsible for the development of a vast number of assessment tools for depression needed for diagnosis. It has also been instrumental in the development of effective treatments of depression like the Cognitive-Behavioral Therapy and Interpersonal Therapy. Thus, much of these accomplishments have lead to some form of relief in those suffering from depression.

Subjectivist Accounts of Depression

Goals of the Current Study

The subjectivist approach to depression research is the alternative employed by researchers who aim to examine people's subjective accounts of depression. When research focuses on depression from the standpoint of individuals, qualitative methods are most likely to be used. The goal of the current study is to provide an account of how people understand and interpret their experience of depression by drawing on in-depth interviews with people suffering from depression. Specifically, this study aims at highlighting the sense-making processes of depression from the point of view of the people who experience depression.

Exploring the Subjectivist Literature on Depression

There are numerous subjectivist studies that investigate the experiences of people who suffer from terminal life-threatening illnesses like AIDS, cancer, Rheumatoid Arthritis, etc. and through the employment of qualitative methodologies like in-depth interviewing (e.g., Drew, S., 2003; Ortiz-Torres, B., Williams, S. P., & Ehrhardt, A. A., 2003; Williams, G., 1984). However, there is a significant dearth of subjectivist studies that explored the experiences of mental illness in general, and depression in particular.

My initial literature searches produced numerous "pathographies", autobiographical or biographical narratives about an experience of illness by the individual who has experienced that illness. Examples of the pathographies that I have encountered in my literature review include Danquah's (1998) "Willow Weep for Me: A Black Woman's Journey through Depression", Endler's (1990) "Holiday of Darkness: A Psychologist's Journey out of Depression", Mays's (1999) "In the Jaws of Black Dogs: A

Memoir of Depression", Styron's (1990) "Darkness Visible: A Memoir of Madness", Plath's (1972) "The Bell Jar", Mairs's (1986) "Plaintext Essays", and Wurtzel's (1994) "Prozac Nation". Although these autobiographical accounts of depression are very instructive, they are not based on systemic data collection nor do they aim to discover underlying patterns or themes in the depression experience.

Another set of subjectivist literature is comprised of studies that focused exclusively on investigating the experiences of depression in women. Specifically, these studies focused on investigating why women become depressed and why depression is a problem that particularly afflicts women. Some such studies, for example, have explored situations (e.g., low-income, poverty) that increase women's risk of becoming depressed (Scattolon, 1999; Walters, Avotri, & Charles, 1999, as cited in Stoppard & McMullen, 2003) while others have focused on how social roles like motherhood increases a women's risk of becoming depressed (Mauthner, 2003; Nicolson, 1999, as cited in Stoppard & McMullen, 2003). Although these studies provide important insights, these are analyzed and presented mainly in a gendered context. Therefore, it did not seem appropriate in the light of the more general objective of this study to include those subjectivist studies that focused only on women's experiences of depression and thus treated gender as the central data collection and analysis informing variable.

Only four studies (Drew, Dobson, & Henderikus, 1999; Kangas, 2001; Karp, 1996; Lewis, 1995) were found to be specifically relevant to the goals of this study. They are identified and hereon reviewed while discussing the critical features of a subjectivist approach to depression. These studies investigated depression among individuals who were either diagnosed by a mental health professional or by the participants themselves.

They included participants of both genders, comprised of different ages, ethnicity, socio-economic classes, education level, and occupational backgrounds. Similarly, each of the four studies utilized qualitative data collection methodology and data analysis and was informed by theoretical frameworks (symbolic interaction theory and discourse analysis) that are subjectivist in character.

The primary objective of each of the four subjectivist studies on depression was to provide the participants an opportunity to present their own understanding of their experiences of depression. In his narrative study, Kangas (2001) aimed at highlighting the lay sense-making processes of depression by drawing on in depth interviews with people suffering from depression. Specifically, he was interested in how people talked about depression and what kind of explanations they gave for their depression. Similarly, the qualitative study conducted by Lewis (1995) investigated what was subjectively experienced as depression and whether individuals themselves defined their experiences as depression. On the other hand, the study by Drew, Dobson and Henderikus (1999), exclusively examined various strategies employed by individuals suffering from depression in order to present themselves in a positive light and to defend their role as a sick person. Finally, sociologist Karp (1996) wanted to let people speak about how their lives, feelings, attitudes, and perspectives have been influenced by depression. The following sections elaborate on the critical assumptions of a subjectivist approach and use the cited four studies to illustrate these assumptions.

How Depression is Conceptualized in a Subjectivist Approach

Underlying a subjectivist epistemology and methodology are certain critical assumptions. First, psychological realities are perceived as constantly evolving rather

than fixed in time. Second, the individual's own perspectives are considered as valid as that of the researchers. Third, the experiential nature of the phenomenon under study and context in which it occurs is important. Fourth, since any phenomenon is considered to be constantly evolving as opposed to fixed in time, the ultimate purpose of research is not necessarily predication and control but is exploration and investigation, and lastly, how the researcher's own values influence the research process and outcome is taken into account (Lincoln & Guba, 1985).

Depression is an 'illness experience' that is constantly evolving rather than a 'disease' fixed in time. In a subjectivist approach, realities are perceived to be multiple, constructed, and holistic and all entities are assumed to be in a state of mutual simultaneous shaping, so that it is impossible to distinguish causes from effects. Depression is conceptualized as an 'illness experience' or 'illness narrative'. Kangas (2001) argues that making sense of the illness experience is a task most sick people engage in after the initial period of falling sick-or even during it. The process of sense making is therefore an active search for meaning in which an attempt is made to answer the question presented by the illness -- 'why me?'. Researchers call this process 'narrative reconstruction', where the biographical interruption posed by illness is woven into the cloth of the individual's life (Bury, 1982; Williams, 1984 as cited in Kangas, 2001). Giving an account of illness and forming an illness narrative is part of coping with illness and its consequences. It is an ongoing and continuous process in which new meanings are found and old meanings replaced, making the illness narrative a storytelling with no end, and is thus difficult to comprehend solely from a singular perspective (Good, 1995 as cited in Kangas, 2001).

In his study of depression, Kangas (2001) distinguished three types of narratives that were guided and shaped by the individual's perception of the cause of their depression. In one storyline, feelings of depression and hopelessness were thought of as resulting from childhood experiences. A second story line focused on the excessive demands and role-conflicts as causes of work related burn-out. A third storyline was formed along symptom-provoking factors, outlining a story of hardship and severe life events during adulthood that led to depression. Although participants in Kangas' study presented various possible explanations of depression, in his conclusion he argues that in the narratives depression was also depicted as a multi-dimensional and holistic illness (Kangas 2001). As such, a single explanation did not necessarily suffice in the sense-making process, even if a core explanation was found and a narrative formed accordingly. It seemed that a single explanation did not structure the entirety of depression.

In the same study described above, making sense of depression entailed that people leaf through the many explanations of depression that shared cultural knowledge provided, and compare their experiences to them. They then proceed to adapt the ones with the most power of explanation in their individual and social lives. Lay perceptions of depression were made of bits and pieces taken from many sources, reflecting the fact that individual, social, and cultural contextualization of depression takes place in an era of increasing reflexive practices, of diminishing faith in a medical authority, and exposure to a wealth of complementary and competing information from multiple sources. Lay theories, perceptions, and explanations of depression were *constructed* and *negotiated* in an increasingly plural and complex environments of knowledge

highlighting the continuously evolving nature of illness like depression (emphases added; Kangas, 2001).

In another study on depression, Karp (1996) explores if and how experiencing an illness like depression demands constant adaptation of the participant's identity, effectively demonstrating the continually evolving nature of depression. To illustrate the changes in the participant's identity during depression, the author conceptualizes the experience as a 'depression career'. He argues that narratives presented by participants in his study show that much of the depression career is caught up with assessing self, redefining self, re-interpreting past selves, and attempting to construct a future self that will "work" better (Karp, 1996, chap. 3).

Karp (1996) identified four likely turning points in the way in which participants viewed themselves and their problem with depression. The first stage was the phase of inchoate feelings during which the participants lacked the vocabulary to label their experiences as depression, followed by a phase during which they could conclude that something was really wrong with them. A crisis stage followed the second phase which thrust the participants into a world of therapeutic experts, and finally, the crisis was resolved by a stage of coming to grips with an illness identity during which they theorized about the cause(s) for their difficulty and evaluated the prospects for getting beyond depression (p. 57). The author also illustrated a similar process that involved the participants' experiences in being treated with medication. This was a process through which participants were transformed into patients who ultimately adopted a medical version of depression's reality (Karp, 1996 chap. 4).

The various means by which participants coped with their depression also presented a continuous process of adaptation whereby each participant tried to cope with depression depending on how s/he understood its meaning at a given moment in time. The means of coping thus coincided with the various stages of depression career. Diversion in the form of activities that make them happy, work, drugs etc. were the primary means of coping during the first stage of inchoate feelings. Trying to fix the feelings of depression was a common means of coping when participants realized that something was really wrong. This included spiritual journeys, immersion in books, etc. A search for 'Dr. Right', a therapist/doctor coupled with the perfect 'pill' that would 'cure' or completely remove the feelings of depression characterized the coping during and after the crisis stage. The author labeled the coping strategy adopted most by the participants when they came to grips with their depression as 'incorporation'. The recognition that the pain of depression was unlikely to disappear eventually provoked a redefinition of its meaning and a reordering of its place in the participant's life (Karp, 1996, chap. 5). This study amply demonstrates how depression is a continually evolving illness experience that not only impacts various aspects of the individual's life but also undergoes changes in the way it is perceived by the individual and is integrated into the sufferer's identity.

The various stages identified by Karp (1996) in the process of depression identity evolution are also reflected in the themes that emerged in the study on depression conducted by Lewis (1995). The participants in the study expressed initial confusion about the nature, causes, and meanings of depression prior to receiving a diagnosis of depression. This confusion demanded a need to find a cause and ultimately to find some meaning in their experience of depression. Some participants in this study initially

avoided seeing themselves as depressed and recognized only retrospectively (Lewis, 1995). Chris was one such participant in the study for whom depression was not a useful label:

> "Mind you, I've been told that what I've had is depression, yes. If somebody hadn't told me it was depression, I wouldn't have been able to say what I thought it was or how it affects you" (p. 9).

The author reported that in the course of the interview, Chris accepted that he might have been depressed at the start of his illness, but claimed that he was no longer depressed (Lewis, 1995). Thus, in this study, although the author identified various themes with respect to the way in which participants identified their problem as depression, the need to explain depression and search for meaning were evident from their stories. Sense making was achieved through a continuous process of questioning the meanings of depression at a particular point in a participant's life.

Legitimizing the individual's voice. In contrast to the objectivist research methodology, subjectivist accounts of depression adopt a 'narrative' or 'life story' approach. As the participants in subjectivist studies of depression are encouraged to present their 'illness narratives' or stories of depression, it provides them with an opportunity to gain a voice. Telling the story becomes a part of healing where the ill person claims her/his body back from medicine and makes sense of the illness in her/his life (Frank, 1992). An illness narrative of depression often also struggles for legitimation of the sufferer's position. According to Good (1995), for the ill, there is always the threat of being defined as less than competent or

capable, and in the case of mental illness like depression, the question of whether the illness itself is self-motivated remains (as cited in Kangas, 2001).

Good (1995) reminds us that an illness narrative always involves the effort to tell the correct story, to patch up the moral rupture presented by illness. Morally justifying their action and non-action therefore becomes vital to the storytellers (as cited in Kangas, 2001). For example, in a study by Drew, Dobson and Henderikus (1999), the narratives generated by the participants who suffered from depression highlighted how different strategies were employed by the participants to position themselves in a positive light and defend their role as a sick person. Dylan, a 23-year-old, single man, indicated his feelings when his girlfriend, who called their relationship "healthy" and "incredibly special", considered ending it in order to pursue an advanced degree in another province:

> "So I was in the role of waiting which was very difficult and a very powerless position relative to the other person. Not that it was easy for her but the level of vulnerability is unquestionably different in that case. You put a lot of yourself out to wait" (p. 9).

Emphasizing the personal and contextual nature of depression. In the subjectivist approach the information about a depressed person's life circumstances and everyday activities are retained because it is assumed that only time and context bound working hypotheses are possible. All entities are in a state of mutual simultaneous shaping, so that it is impossible to distinguish causes from effects. These personal details, in turn, help to cast new light on experiences that might be counted as instances of depression by researchers or labeled as depressive symptoms by health professionals.

Stoppard (2000) argues that recontextualizing depression in this manner enables researchers or therapists to see depression not just as an individual pathology requiring individual change but as embedded in relationships and social settings. Recontextualizing highlights the context of people's experiences by paying special attention to the details of their lives and acts as a means to highlight questions about power, ideologies and practices of a particular culture. In addition, depression narratives facilitate the understanding of the underlying, overarching suffering central to an illness as opposed to individual suffering that is lost when depression is presented merely as symptoms like hopelessness, sadness, lack of interest, insomnia or hypersomnia and is contextualized within macro structures mentioned by Frank (1992).

In the study conducted by Kangas (2001), participants not only presented their experiences of depression in what he terms individual contextualization, which contains an attempt to find and give meaning and explanations to the origin and etiology of illness in the individual's life, but also within cultural contextualization. This consists of the use and contemplation of shared cultural knowledge regarding the illness: public images, cultural expectations, attitudes and norms, disciplinary theories, etc. Thus the stories presented by participants were not only individual stories but also were descriptions of what is wrong in society from the individual's perspective; what kind of structural and social factors created unbeneficial or unwanted circumstances and environments. Accounts of depression thus reflected not only the psychological conditions that shaped an individual's life, but also the cultural, social and structural circumstances that positioned individuals in a specific society and time (Kangas, 2001).

In Kangas' study (2001), women mentioned excessive demands stemming mainly from work or the dual careers rather than solely from family as a likely etiological factor for their depression. One 42-year-old woman commented:

> "I think that it was the combining of work and family that wore me out...Because I felt that I had to divide myself into two. I had to be a good mother at home and cook and tend to the garden, and, on the other hand, be good at work, helpful and multilingual and cognizant of all software and everything" (p. 84).

In another study conducted by Lewis (1995) that explored people's narratives of depression, although some people utilized individualized, biochemical explanations of depression, others found these unsatisfactory and presented social circumstances like unemployment to explain their depression. One of the participants in this study suggested that he could not pull himself out of depression because he was unemployed, that unemployment was both the cause of his depression and trapped him within depression. At the time he had been told that he could only help himself:

> "They said to me, 'it's up to you to pull out now.' I say, 'I can't'. I said, 'If I got a job tomorrow-this would all go, in a week or a fortnight-it'd go, it'd go" (p. 8).

The study on depression conducted by Drew, Dobson and Henderikus (1999) identified four different types of discourse strategies that depressed clients used to explain their depression. The narratives illustrated how different strategies were employed by the participants to position themselves in a positive light and defend their role as a sick person. One participant, for example, began by blaming her depression on

imperfect societal practices. Brenda, a 47-year-old widow, initially related her lifelong "tendency to be depressed" to having been sexually assaulted by her brother-in-law at age 11. Although she blamed him directly for the loss of her "happy and feisty" character, she argued that the environment in which she grew up had robbed her of the means by which to protect herself from him:

> "I don't think people did (talked about it) in general in those days, especially Scotland, but I know in my family it was taboo and I don't think there's any excuse for it. I don't think it should have been like that. It makes me angry...." (Drew, Dobson and Henderikus, 1999, p. 11).

Here she not only highlights her own sense of helplessness in preventing the sexual assault but also the powerlessness that results from the cultural notion that treats discussion of sex as a taboo for society in general and for women in particular.

In his narrative study of depression, Karp (1996) uses his participants' stories to highlight and conclude how larger social and cultural factors contribute to the very personal illness like depression. He achieves this task by presenting a theoretical equation that highlights how cultural dimensions of contemporary American society provide the context for the collective vulnerability to emotional distress. This equation is: *Medicalization + Disconnection + Postmodernization = Personal Dislocation.*

The author argues that the definition of depression as a 'disease' and its consequent implications for research and treatment, medicalization of American society, the level of disconnection experienced by individuals as a result of absence of meaningful work and lack of sustaining intimate ties, and the effects of a highly technical society on

the self foster rootlessness and social disintegration that unquestionably contributes to the growth of emotional disorders like depression (1996, chap. 7).

Summary. The subjectivist approach to depression not only conceptualizes the psychological phenomenon as an illness experience but also highlights how individual meanings of illness like depression are shaped and influenced by larger social, cultural, and political structures, shifting the focus from a purely individualistic view of depression to a holistic, contextual view of it.

How Depression is Studied in a Subjectivist Approach

In the subjectivist paradigm, depression is understood and conceptualized as an 'illness experience' where individual perceptions, interpretations based in past experience, learned patterns of coping and local explanatory models as well as the personal virtuosity of metaphors about illness are all brought together (Kleinman & Seeman, 2000).

Participants are those who identify themselves as experiencing depression. Conceptualizing depression as an illness experience is primarily achieved through a methodology that follows from the subjectivist epistemological axiom that psychological realities are multiple, constructed, and holistic. In the subjectivist approach, the participants included in the studies are not only those who have been formally 'diagnosed' as depressed or having a 'Major Depressive Episode' but also those who self-identify as experiencing depression at the time of the study or have experienced it at any time in the past.

Sociologist Karp (1996) conducted a study to understand the phenomenology of depression experience. He collected and analyzed in-depth interviews of 50 people who

had been officially diagnosed with depression. Although he interviewed people with 'official diagnoses' of depression, his information was gathered from the participants themselves. The author did not utilize DSM criteria or questionnaires to either objectively determine their diagnosis or severity of symptoms. Similarly, he acknowledged that those familiar with the psychiatric lingo might want to know, for example, how many of those interviewed in his study, could be categorized as having suffered major depression, dysthymic conditions, exogenous depressions, endogenous depressions, and so on. He argued that since part of his thinking about depression included the arbitrariness and socially constructed character of psychiatric diagnosis, he was only interested in how people came to be placed and placed themselves in one or another category (Karp, 1996). Thus, in subjectivist research, the focus is on if and how individuals identify and explain themselves in different categories of depression.

Participants are not categorized and assigned into artificial groupings. Unlike in the objectivist methodology, participants in subjectivist studies of depression are not separated into categories or groups of those with or without depression, a certain 'type' of depression (MDD, Dysthymia, endogenous depression, or exogenous depression), or individuals with certain intensity of symptoms (mild, moderate, or severe).

In addition, participants are not recruited or segregated based on the demographic factors of age, gender, ethnicity, class, or occupation. Instead, these factors are investigated and understood as an integral, interwoven part of the way in which an illness like depression is understood, given meaning to, and experienced by individuals.

In my review of four subjectivist studies on depression, participants ranged from the ages of 36 to 56, 23 to 57, 20 to 70, and 20 to 60 years respectively (Drew, Dobson,

& Henderikus, 1999; Kanga, 2001; Karp, 1996; Lewis, 1995). Similarly, all four studies included both males and females, comprised of participants from different ethnicities like European, European-American, African-American, Native-American, French-Canadian, and East Indian, and came from varied educational and occupational backgrounds that ranged from incomplete secondary school education to university level education and unemployed persons to professionals respectively (Drew, Dobson, & Henderikus, 1999; Kanga, 2001; Karp, 1996; Lewis, 1995).

'Narratives' are a primary source of data. One of the most frequently utilized methodologies that effectively examine the illness experience is the 'narrative' or 'life story' told by people who experience depression. The term *narrative* is used both as text and method. First, it is employed interchangeably with *story* to refer to the process of storytelling as well as the product, the story itself. Second, it is used as a method of inquiry, a qualitative research approach that solicits and analyzes personal accounts as stories and allows participants to use their own words and categories to describe their life experiences (Gordon & Paci, 1995, as cited in Muller, 1999; Drew, Dobson, & Henderikus, 1999; Kanga, 2001; Karp, 1996; Lewis, 1995).

The personal accounts or 'narratives' of depression are usually generated by responding to a semi-structured interview schedule composed mainly of open-ended questions that are presented in a very flexible manner, based on the purpose of the study, the content of the earlier narratives generated so far by the participants, and are often altered according to the needs of the participants. This methodology is in stark contrast to the adaptation of either the rigid DSM criteria or pre-formulated questionnaires like the BDI-II where individuals are forced to respond to close-ended questions or express their

agreements to single sentence statements like "As I look back, I see a lot of failures", "I feel like crying but I can't", or "I feel utterly worthless" (BDI-II; Beck, Steer, and Brown, 1996).

In the study conducted by Kangas (2001), he first asked participants to tell the story of their depression with minimum interference by the interviewer. After this initial question, and based on the information disclosed on the accounts, more detailed questions concerning the experience and meaning of depression were asked with the help of a semi-structured interview guide. Similarly, in a narrative study conducted by Lewis (1995), no fixed format for an interview was utilized. Although a broad interview schedule was used by the interviewer, it did not determine the structure of the interview, since the aim of the interviewing was to encourage participants to structure their own accounts of their experiences, and to explore their perspectives.

The study conducted by Karp (1996) mentioned earlier, also utilized the interview method to generate people's narratives of depression. He began the interview by asking the person to trace the history of his or her experiences with depression from "the first moment you realized that something was wrong with you, even if you did not initially define the problem as depression." (p. 13). This broad opening question normally led to conversation that provided information on what depression is like, the experience of hospitalization, views on whether depression should be considered an illness, feelings about therapeutic experts, depression's impact on relations with family and friends, the influence of depression on work, feelings about using psychotropic medication, and coping strategies (Karp, 1996). One of the questions asked by Karp (1996) further indicates the open-ended and non-intrusive nature of this methodology and how it

actively prevents the reduction of experience of depression into a disease entity: "If you were trying to convey to somebody what the feeling of depression is about, how would you try to do it... How would you go about describing it?" (p. 28).

The answers generated in response to such open-ended question are also indicative of how this methodology enables the participants to present their own descriptions of depression, using culturally and linguistically available metaphors without necessarily constraining or reducing their experience into categories of sadness, pessimism, self-dislike, or worthlessness (BDI-II; Beck, Steer, and Brown, 1996). For example, consider the following descriptions presented by participants in the study conducted by Kangas (2001):

> "I cannot feel at home anywhere, because I sort of dys-exist, I only subsist on a dark tube with no ends...", "It is so total. ...There is no reason to wake up in the morning. I just let the blinds stay down..." (p. 86).

The descriptions of depression presented in the study conducted by Karp (1996) similarly highlight the utilization of rich metaphors by participants:

> "...There is a storm above you. It's a dark storm between your ears. That's how I see it. ...I mean it's doom, it's hopelessness, down the water is death, and up is just a dark storm that you want to get away from, but can't. ...", " A sense of being trapped, or being caged, sort of like an animal, like a tiger pacing in a cage. That's sort of how I feel. I feel like I'm in a cage and I'm trapped, and I can't get out and it's night time and daylight is never going to come. ...", or "I would say it kind of feels like somebody is holding a match that's lit and just the flame is really hot and

you're trying to stand it, and it's just consuming you more and more and then it just gets down to the end and there's no more, and the consuming part is just complete hopelessness. ..." (p. 29)

Kangas (2001) argues that accounts of depression presented by participants in his study described depression as an experience intertwined with everyday life. Depression in the accounts of the participants in his study were not presented as a disease, but as a social and personal problem, a feeling or condition that disabled the sufferer and restrained his/her ability to act in his/her ordinary social relations. Similarly, Lewis (1995), in her summary of findings argues that the meaning of depression to individuals in her study was highly variable and subjective. Some individuals did manage to identify possible causes of depression, in their accounts and explanations of how they came to be depressed. However, it was not clear that these were seen as fully explaining their experiences of depression. Depression itself might remain a mystery to those who were depressed.

Theoretical interpretive techniques are used to analyze the 'narratives'. Various theoretical orientations can inform the data analysis. Two of the subjectivist studies cited were informed by symbolic interaction theory (Lewis, 1995; Karp, 1996) while another study by Drew, Dobson and Henderikus (1999) was informed by the 'discourse analysis' orientation.

According to a symbolic interactionist theory, all objects, events, and situations acquire their meanings through processes of human interpretation. The meanings attached to objects, events, and situations are not built into them. Instead, they are products of our responses to them. In this regard, all human experience is an ongoing exercise in sense-

making (Karp, 1996). Lewis (1995) incorporated grounded theory and discourse analytic techniques within symbolic interaction theory whereby a novel methodology of "thematic analysis" was developed to answer the research questions. Thematic analysis drew on the grounded theory in looking at what was experienced, and interpretive discourse analytic techniques in looking at the construction of meaning within accounts. Similarly, the study by Karp (1996) employed the 'depression career' perspective within the symbolic interaction theory to identify and explain how the participant's identity underwent constant evolution through various stages as a result of experiencing depression.

In the study by Drew, Dobson and Henderikus (1995), the authors adopted a discourse analysis approach to analyze the narratives generated by the participants. Discourse analysis is interested not only in a person's experience of the social context but in what happens when that experience is communicated to others. Thus, within discourse analysis language is never viewed as a neutral transmitter for replying dispassionate descriptions of something that has occurred or was experienced. Rather, people organize their talk rhetorically, that is they argue for a particular description of events or phenomena and struggle against other possible competing descriptions. Hence language can be seen to have an active, functional, constructive orientation. Since the authors were interested in exploring the kinds of positionings, constructions, or other negotiations which might be going on in the outward social accomplishment of depression, the theoretical approach of discourse analysis provides the appropriate and adequate context to demonstrate how people who experience depression actively present and construct their identity in a positive light (Drew, Dobson and Henderikus, 1995).

Summary. In adopting a subjectivist paradigm, the four studies that were reviewed prevented the reductionism and operationalization of experience of depression in to a 'disease' or 'mental disorder' but were also able to implement an alternative methodology that allows for the conceptualization and investigation of depression as an 'illness experience'.

Significance of the Current Study

According to Frank (1997), the act of writing or talking about the illness experience enables reclaiming of voice and it is in the reclaiming of narrative authority that the seeds of healing and wholeness can be found. He further argues that illness stories matter because they enhance the self-consciousness of the ill and aid them in developing their distinctive community (Frank, 1997). There is an abundance of research in the realm of life threatening illnesses like cancer, AIDS, breast cancer or multiple sclerosis that has created a distinct space for the experiential aspects of these illnesses to be represented and incorporated into service delivery practices and into policy decisions. There is lack of such types of research, however, on mental illnesses in general and depression in particular.

It is important to examine and study what individuals who suffer from depression have to say about their illness because a reaction to our contemporary medical model, one so dominated by a biophysical understanding of illness, which virtually ignores the experiential aspects of illness, is the need of the hour. Explaining and understanding depression must include looking at the meaning of subjective experiences and this may well imply a revision of the concept of depression.

Thus, this study is an attempt to address an existing knowledge gap in the current research on depression by highlighting the experience of depression from the standpoint of people who are depressed, grounded in their own stories about being depressed. Such a research enterprise can act as an important stepping-stone towards generating a better understanding of the phenomenon of depression for contemporary and future researchers. Similarly, it can highlight future areas of research on depression which are traditionally neglected in current research, such as how depression shapes one's identity, personal variables that contribute to acceptance or rejection of treatment modalities, interaction with and changes in social structures of a depressed individual's life. Apart from this, a subjective understanding of the experience of depression can open doors for revising current criteria for depression and psychometric instruments like SCID-I (First, Spitzer, Gibon, & Williams, 1997) and BDI- II (Beck, Steer, and Brown, 1996) by making them more inclusive and client relevant.

Another reason for exploring the experience of depression through an alternative perspective is more personal in nature. I have always struggled with a strong sense of discomfort, doubt, and dissatisfaction with the traditional explanations offered to describe the phenomenon of depression whose underlying assumptions are that of prevalent objectivist scientific paradigm. Part of the therapy is also spent in convincing the client that this mental illness is her/his own responsibility without ever acknowledging how the client perceives her/his depression in the context of larger social forces. This leaves a big gap between the doctor/therapist's explanation of client's mental illness and that of the client's understanding of the mental illness. Coming from a cultural upbringing where a person's existence is invariably tied to her/his family and social relationships, including

when one is experiencing a disruption in normal life, an unrelenting belief in the virtues of individualism reflected in the traditional explanations of depression have always disturbed me.

The feelings of discomfort and doubt became stronger during my training as a social worker when I got my first opportunity to closely examine and evaluate the philosophical assumptions underlying my education in psychology. But this training also introduced and provided me with other alternative perspectives for challenging and exploring the popular assumptions underlying the nature of psychological knowledge. Some of these alternative perspectives include constructivist philosophies (e.g., radical, and critical hermeneutics, social constructionism, and phenomenology) that underlie the qualitative research tradition. When I started to work on exploring topics for my thesis, a requirement of my Master's program in Clinical Psychology, one thing I was sure about was that I wanted to do research that would explore some aspect of depression due to my personal fascination with it for many years. But my doubts and discomforts discussed earlier returned. The emotional and intellectual struggle to deal with these anxieties led to the decision of using a subjectivist approach to studying depression.

This emphasis on "lived experience" of individuals, the importance of multiple perspectives, the existence of context-bound constructed social realities and the impact of the researcher on the research process seemed to provide an ideal vehicle for exploring the personal experience of depression as presented by people who suffer from depression.

Specific Research Questions

The present study attempts to answer the following questions: How do people perceive, make sense of, and respond to their experience of depression? What personal

meanings do people generate from their experience of depression? How do people generate meanings from depression? What experiences and themes do they emphasize in their stories, and what do they leave out?

Method

This study is based on what Norman Denzin (1989) terms "subjective knowing", which is to draw on "the personal experience of others in a effort to form an understanding and interpretation of a particular phenomenon" (p. 27). In this study I use the "narrative" or the "life story" methodology to examine the experiences of people living with depression. The term narrative is used both as a text and a method. First, it is employed interchangeably with story to refer to the process of storytelling. It also refers to the product, the story itself. Second, it is used as a method of inquiry, a qualitative research approach that solicits and analyzes personal accounts as stories, and allows participants to use their own words and categories to describe their life experiences (Gordon & Paci, as cited in Muller, 1999). Life stories, as well as other narrative forms, are co-constructed through dialogue (Reissman, 1993; Titon, 1980). Because this study concerns people who experience depression, much of their life stories can be considered illness narratives.

According to Frank (1997), the act of writing or talking about the illness experience enables reclaiming of voice and it is in the reclaiming of narrative authority that the seeds of healing and wholeness can be found. Lieblich, Mashiach, and Zilber (1998) argue that stories imitate life and present an inner reality to the outside world; at the same time, however, they shape and construct the narrator's personality and reality. The story is one's identity, a story created, told, revised, and retold throughout life.

People know or discover themselves, and revel themselves to others, by the stories they tell (p. 7).

Participants

Recruitment for the study began following the IRB approval from the EIU and from the ethics committee at the Psychology Department. The sample size for the study was determined by following the suggestions offered by Josselson and Lieblich (2003) who assert that the number of participants necessary is inversely proportional to the intensiveness of the study. Relatively few deep, long intensive interviews observed in highly detailed, multilayered ways would yield about as much material as many shorter, less intensive texts (p. 268). Two individuals, one male and one female were interviewed for the present study. The decision to interview two individuals was also influenced by the fact that there was only one researcher (myself) who would collect and analyze the data, and by the limited amount of time available for interviewing and analyzing the content of the interviews. Furthermore the narratives generated by both participants contained major themes and variations on experiences of depression. An equal number of female and male individuals were interviewed to ensure equal representation of the sexes.

The individuals who were interviewed, however, were not limited to any particular ethnicity, years of education, socioeconomic background, or number of years and type of treatment. This study does not aim to establish trends nor to characterize group differences. Its goal is to highlight individual experiences and demonstrate variability. However, the sample was limited to adults (above 18 years old).

Individuals who had been formally diagnosed with a Major Depressive Disorder (MDD) by a mental health professional like a psychiatrist or a psychotherapist were

selected as participants for the current study. The criterion of a formal diagnosis of MDD was required in order to ensure purposeful, criterion-based sampling. According to Patton (1990), purposeful sampling is the process of selecting information rich cases that deal with issues of central importance to the purpose of the research (p. 169). The logic of criterion sampling is to review and study all cases that meet some predetermined criterion of importance (Patton, 1990, p. 176). The requirement of a formal diagnosis of MDD ensured the exclusion of individuals with other types of depressive disorders like Bipolar Depressive Disorder or Depression due to a General Medical Condition. I am primarily interested in experiences of Major Depressive Disorder. These other illnesses encompass completely different illness experiences, the exploration of which was beyond the scope of this study.

Procedure

Pre-interview. The participants for the study were recruited by approaching a licensed psychologist involved in private practice in the towns of Charleston and Mattoon, Illinois. The psychologist received an explanation of the purpose and nature of the study along with the assurance of maintaining confidentiality of clients who would agree to participate in the study. The psychologist was then requested to inform her clients about the study and she was also provided with my phone number. Participants who were interested in the study contacted me by phone, at which time I explained that I was a graduate student doing a study for my Master's thesis. I also explained the purpose of the study in greater depth, and what their involvement would entail. After answering any further questions they had at the time, I arranged an interview time and place that was convenient for each participant.

Interview. Each interview was conducted by me, in a location that was convenient for each participant. Both interviews took place at the interview room in the Psychology Department of my university. Each interview was tape recorded and lasted for an hour and fifteen minutes. About ten to fifteen minutes were spent talking to each participant before and after the interview. Before the interview, this conversation consisted of typical conversation that one might have with another whom they've never met (e.g. weather, home,). After the interview, participants were thanked for their participation in the study. They were also encouraged to share their views about participating in the study. I recorded these as field notes.

Before the interview began, I read and discussed the informed consent form with each participant. The agreement explained the purpose of the study, the time requirement, how confidentiality would be maintained, that their participation was voluntary and that they could withdraw from the study at any time. Interviews did not begin till the participants said that they understood the agreement and we both signed the consent form. Each participant was given a signed copy of the form to keep.

In-depth interviewing was chosen as a method of data collection because it is the most suitable method for generating narratives of particular research interest (in this case, depression). The participants were also more likely to be already familiar with being interviewed and with interview settings given their current or past therapeutic experiences. Therefore, such a setting ensured the participants' ease and also facilitated rapport building which is absolutely necessary to generate information-rich, multilayered narratives from participants. I have also been trained to carry out clinical interviews

during my Master's programs in clinical psychology and social work. I worked as a mental health counselor at EIU Counseling Center for the past two years where the primary mode of therapeutic intervention was individual interviews. The professional experiences in conducting interviews, in addition to the formal training in interviewing, prepared me for such aspects of interviewing as rapport building, being sensitive and empathic to the interviewee and the information being shared, probing, and addressing any emotional consequences that could result from participating and sharing one's story of mental illness in general, and depression in particular.

Each participant in the study was first asked a set of standard biographical questions that required for short, structured, direct answers. These questions helped to obtain information regarding participants' age, sex, number of years of education, socioeconomic background, number of years of treatment, and various types of treatment (medication or pills, individual counseling, group counseling, hospitalization etc.). In addition, the initial 10 to 20 minutes spent talking about age, socioeconomic status, etc. helped to create a climate of trust, communication, and self-disclosure.

The standard biographical questions were followed by the "grand tour" or main questions of the study. According to Spardely (1979) and Werner and Schoepfle (1987), 'grand tour' questions seek to elicit understanding, feelings, key terms, and major features or attributes about people, acts, time, goals, expectations, motivations, and experiences (as cited in Crabtree & Miller, 1999). The following were the "grand tour" questions for the current study:

1. Tell me the story of your depression.

2. How has experiencing a mental illness like depression changed your life? If you were to describe yourself before and after you became ill, how would you do it?
3. If you were trying to convey to somebody what it feels to be depressed, how would you try to do it? How would you go about describing it?
4. What does experiencing depression mean to you?

In addition to the grand tour questions a number of "category questions" were also utilized as probes. Category questions simply seek elaboration and/or clarification of all parts, settings, relationships, activities, and relative worth or value of the domain being discussed (Crabtree & Miller, 1999, p. 98). Following was a list of category questions that were used for this study:

1. How has the experience of depression affected your life?
2. How do you deal with depression?
3. How has depression affected your relations with your family, friends, and colleagues at work?
4. Are you seeking counseling? What brought you to counseling?
5. Did your doctor/counselor tell you that you have depression? How were you diagnosed? How did you feel when you were informed? What effect did this have on you?
6. Do you take medication for your depression? How do you feel about taking medication?
7. What other therapies or solutions have you or are you undertaking to deal with your depression?

8. What were and are your impressions of the doctors/therapists you've consulted in the past and the one you are seeing right now? How would you describe yours relationship with these doctors/therapists?

Debriefing. A half-hour debriefing session was conducted following the data collection interview. Debriefing was carried out by first thanking each participant for their interest, time, and cooperation for the study. Each participant was reminded of the purpose of the study. The debriefing also include participant's responses to questions like how did you feel about telling your story? Was this experience useful/useless to you and how? Would you like to make any suggestions? Do you have any questions regarding participation in the study?

I was very much aware of the possibility, from my previous and current experiences of working with people who struggle with a mental illness like depression, that talking about such an experience is likely to generate strong negative emotions. As a human being first and a researcher next, I intended to address this possibility by being empathic and respectful to their stories and the strong emotions that are likely to be generated. Similarly, my strong belief in one of the assumptions of philosophical hermeneutics that understanding is participative, conversational, and dialogic, I believe that the process of construction of stories will be co-constructing in its nature. Therefore, both the participants and I are equally involved in that process through a relationship of trust and honesty.

Data Analysis

Interpreting the narratives. Although I have been trained as a clinician and possess some experience in working with people who have depression, as a person who has never suffered depression herself, I consider myself as an "outsider" in this research process. I am also a South Asian, much younger, woman from a different socio-economic background. For both the participants I interviewed, our lives are separate by chasm of age, background, and experience. Hence, I was aware that at times during the study, I could not relate to what the participants were telling me about their lives. And that I had to be particularly attentive to their interpretations as well as my own.

During the entire duration of this study I was aware of my own thoughts, beliefs, biases, and interpretations about depression. These are informed by my professional training as a clinician, my prior experiences in working with people who experienced depression, and my cultural and personal experience. But ultimately all these experiences have contributed to my understanding of depression. I am also aware that the process of interpretation was a reflexive activity (Coffey & Atkinson, 1996). My prior experiences and my research stance (my philosophical and theoretical perspectives and approach to research) has influenced what I would be asking and looking for in the stories. My continuous reading of various literatures related to my study also influenced the interpretation of the stories.

Since the aim of this study was to explore the meanings and experiences of depression form the perspectives of people who are living with depression and highlight the sense-making processes of depression, an analytic approach proposed by Lieblich, Mashiach, and Ziber (1998) to analyzing stories was utilized. According to this approach,

reading, interpreting, and analyzing life stories or narratives can be conducted along the following two dimensions: (a) *holistic versus categorical* and (b) *content versus form* (emphases as in original; p. 12). In the first dimension, a holistic approach takes the life story of a person as a whole, and sections of the text are interpreted in the context of other parts of the narrative. In contrast, when working from a categorical perspective, the original story is dissected, and sections or single words belonging to pre-defined category are collected from the entire story. The holistic approach is preferred when the person as a whole, that is, her or his development to the current position, is what the study aims to explore, while the categorical approach may be adopted when the researcher is primarily interested in a problem or a phenomenon shared by a group of people (Lieblich, Mashiach, & Ziber, 1998, p. 12). Thus, the current study adopted the holistic approach given its goals.

The second dimension refers to the distinction between the content and the form of a story. According to Lieblich, Mashiach, and Ziber (1998), analysis can be conducted on the explicit content of an account from the teller's point of view, or on implicit content by asking about the meaning that the story, or certain sections of it, convey (p.12). On the other hand, analysis can be done on the structure of the plot, the sequencing of events, its relation to the time axis, its complexity and coherence, the feelings evoked by the story, the style of the narrative, the choice of metaphors or words and so forth (Lieblich, Mashiach, & Ziber, 1998, p. 13). Both content and form of the narratives were of interest in the current study.

The two dimensions proposed by Lieblich, Mashiach, and Ziber (1998) are then combined resulting in four strategies or methods of analysis: (a) Holistic-Content; (b)

Holistic-Form; (c) Categorical-Content; and (d) Categorical-Form. Given the goals of the current study, the first two analytic strategies were adopted.

Holistic-content analysis of narratives. This type of analysis was adopted in order to address the following specific research questions: 'What are some of the personal meanings that people derive from their experience of depression?' and 'When relating their experience of depression, what themes are emphasized in their narration? What themes are left out?"

A holistic-content analysis takes into consideration the entire story and focuses on its content. In this form of analysis the material is read several times until a pattern emerges, usually in the form of foci of the entire story. The researcher notes in writing her initial and global impressions while reading the material which might include exceptions to the general impression as well as the unusual features of the story that catches her attention. Through multiple readings of the story from beginning to end, special foci of content or themes are decided (Lieblich, Mashiach, & Ziber, 1998, p. 62).

A holistic-content analysis was carried out separately for each story. Each story was read several times till some global impressions emerged. The theme of loss, in the form of loved ones, job, social connectedness, and a functional sense of self emerged as a common and repetitive theme in both stories. This foci was identified after numerous readings and the repetition of this theme in different context of participants' lives. Personal meanings of and suffering involved in depression emerged after a close examinations of the metaphors used by both participants to describe what it feels to be depressed. Attention to the amount of space devoted and details present about anti-depressant medications and mental health professionals highlighted the theme of

acceptance of the cultural explanations for depression. The consequences of experiencing a mental illness like depression and some of the unique ways that participants adapted to cope with depression also emerged as significant themes.

Holistic-form analysis of narratives. This type of analysis was adopted to address this specific research question: 'What changes in the participants' identity and life occur as they undergo depression?'

Holistic-form analysis was carried out separately on each narrative of depression just as holistic-content analysis. Holistic-form analysis also looks at the entire story or narrative but the focus is on the formal aspects rather than the narrative's content. Its clearest expression is found when the plots or structures of complete narratives are looked at or analyzed. According to Gergen and Gergen (1988), every story, whether oral or written, can be formally characterized by the progression of its plot, which can be discerned by "plot analysis." (as cited in Lieblich, Mashiach, & Ziber, 1998).
The "plot analysis" of each story involved an examination of its structure, plot, and important turning points that shed light on the entire narrative. Through this analysis one story clearly emerged as a story of hope whereas another emerged as a tragedy. Similarly, one participant constructed her story in such a manner that it ascends towards the more positive present moment in her life while the other participant created a narrative of depression where by it descends towards the present moment in his life from a more positive moments and situations. The examination of the turning points in each of the story illuminated the process of continual adaptation of new identities by each of the participants. It also highlighted how an illness like depression demands a revision of identity for successful integration of it in the participants' lives.

I also examined the narratives in terms of Frank's (1998) typology of narrative forms found in illness stories. Frank has presented the following three narrative structures—the skeletons on which many illness stories are fleshed out: When the ill person's answer to "How are you?" is to repeat everything that treatment has already done, is doing, and will be able to do if the present efforts fail, then a restitution story is being told. Restitution stories are shaped by a natural desire to return to health, but also by the assumption of society and institutional medicine that every problem can be remedied, and the expectation that individuals will do whatever possible to return to health. Diametrically opposed to the restitution narrative is the chaos narrative. In a chaos story, the disability experienced as a result of the illness can only increase for the sufferer, pain will never remit, and professionals are either unable to understand what is wrong or unable to treat it. Chaos narratives also lack a real plot or a structure and they elicit strong emotional responses in the listener. Frank argues that chaos stories are usually punctuated by "and then" constructions where the narrator goes from one calamity to another as a result of the illness.

The third narrative type is the quest narrative. When the teller of the story claims new qualities of self and believes illness has been responsible for these changes, a quest narrative is being told. Quest narratives are about illness leading to new insights. They are based on a claim that the ill person now sees in to a depth that illness has made visible (Frank, 1998). I draw on the broad narrative forms of restitution, chaos, and quest as another way to think with the participants' stories in this study. I will discuss these narrative forms in further detail as they relate to different aspects of the stories.

Procedures of Verification for the Current Study

The traditional criteria for evaluation or verification of data analysis are reliability and validity. These criteria are mainly quantitative, expressed in coefficients of correlation or similar measures, and typically require large data sets. While some scholars believe that the same should apply for all research, including narrative (or qualitative research), this is difficult to implement given the nature of narrative data (Altheide & Johnson, 1994, as cited in Lieblich, Mashiach, & Ziber, 1998). Lincoln and Guba (1985) have proposed alternative terms that, they contend, adhere more to naturalistic or qualitative axioms and inquiry. They use the terms "credibility," "dependability," and "confirmability" as the equivalents for validity and reliability (p. 300).

Credibility. It can be defined as a process of verification where by one can establish confidence in the "truth value" of the findings of a particular inquiry for the subjects with which and the context in which the inquiry was carried out (Lincoln & Guba, 1985). Three approaches were utilized to ensure credibility for this study, first of which was described by Lincoln & Guba (1985) as "prolonged engagement". This requires the researcher to be aware of likely distortions by being familiar with her or his own personal distortions and those that might be induced, either unintentionally or intentionally by respondents (p. 302). The personal distortions for the present study were likely to result from some of my perceptions of the cultural difference manifested in the appearance, style and accent of speaking, values, beliefs, and attitudes and my personal beliefs about the nature of mental illness in general and depression in particular.

On the other hand, Lincoln and Guba (1985) argue that unintentional distortions could take the form of perceptual distortions and selective perception, retrospective

distortion and selectivity, misconstruction of investigator's questions, and hence, the answers given, and situated motives, such as wanting to please the investigator (emphases as in original; p. 302). Some of the intended distortions might include lying by participants to deceive or confuse the researcher under circumstances where the sharing of certain information might be perceived by them as too self-threatening. Thus, the purpose of prolonged engagement is to render the inquirer to be aware of multiple influences -- the mutual shapers and contextual factor -- that impinge upon the phenomenon being studied (Lincoln & Guba, 1985).

In order to achieve prolonged engagement for the current study, sufficient time was spent during the interview stage of data collection for the elicitation of relevant information. Similarly, during the entire data collection and data analysis process, especially following both the interviews, personal thoughts, feelings, and reflections evoked during and after were noted in order to detect and take account of personal distortions. The feelings of sadness that I experienced when one of the participants described her depression as 'dance of death', the sense of triumph shared with the participant at the end of the same story, and the very strong feeling of uneasiness and a need to escape the story at the end of another story formed some of the personal feelings evoked by the participants. These same feelings were revisited during the interpretation stage when they shed a light on their form.

How my prior training in social work that has included the examination of some of the social, structural, and political inequalities that women experience were activated while listening to the story of the female participant of this study. On the other hand, my personal thoughts about medicalization of mental illness and increasing use of

medications to address suffering were evoked when participants talked about their experiences of medication and mental health professionals. These feelings and personal reflections were noted at various times during he study. These included immediately following the interview, following the transcription, during and after the reading of the stories, and during the interpretation stage of the study. Finally, sufficient time and empathy were utilized to establish rapport and trust with the participants in order to explore those occasions during the interview when participant's intentional distortions arise as a result of fear, shame, or lying. One such occasion for the female participant was when she talked about feeling defective and useless in the eyes of her husband following the stroke. The feelings of shame and rejection became apparent when she became teary eyed during the story. She was given enough time to talk about these feelings and reframing statements like, 'Seems like that was a particularly difficult time for you' were utilized to convey empathy.

The second method of achieving credibility is that of "persistent observation". The purpose of persistent observation is to identify those characteristics and elements in the situation that are most relevant to the problem or issue being pursued and focusing on them in detail. This can be achieved by continuously engaging in tentative labeling of what are taken as salient factors and then exploring them in detail, to the point where either the initial assessment is seen to be erroneous, or the factors are understood in a nonsuperficial way (Lincoln & Guba, 1985). During the interview stage, I felt that for one of the participants, spirituality and a special relationship with God formed an important element. Therefore she was encouraged to talk in detail about how this was connected with her experiences of depression. This kind of persistent observation helped

me to further highlight the theme of connection in that particular story. Similarly, during the narration of the second story, it became clear that the participant's experience at the Menniger clinic had significantly impacted his understanding of depression. Hence, this element was revisited in the context of perceptions of mental health professionals and how the participant's subconscious could influence his depression.

Finally, "member checks" were utilized to ensure credibility. It is a method whereby data, analytic categories, interpretations, and conclusions are tested with members of those stakeholding groups from whom the data were originally collected (Lincoln & Guba, 1985). For the current study, a brief sketch of the themes and patterns generated after the analysis was provided to each participant in order to obtain their feedback. Both the participants expressed their agreement with the major themes and patterns generated during the analysis. The male participant endorsed the part of the analysis that examined the way experiencing an illness like depression demands a constant evolution of sufferer's identity while the female participant agreed that she was able to see herself in a new light as a result of experiencing depression in her feedback. Thus both participants were given an opportunity to react to the validity of the constructions that were made by me.

Dependability. It can be defined as a process of verification where by one can determine whether the findings of an inquiry would be repeated if the inquiry were replicated with the same (or similar) subjects in the same (or similar) context (Lincoln & Guba, 1985). Lincoln & Guba (1985) argue that since there can be no validity without reliability (and thus no credibility without dependability), a demonstration of the former is sufficient to establish the latter. If it is possible using the techniques to show that a

study has that quality, it ought not be necessary to demonstrate dependability separately (p. 316).

Although Lincoln and Guba (1985) argue that ideally separate and more direct techniques must be utilized to ensure dependability of the study, some of the techniques suggested by them were more appropriate for large qualitative studies that comprise of bigger sample size and therefore large amount of data. Examples of such techniques include having two separate teams of researchers carry independent inquiry of the data gathered and having the data and process of data collection audited by an independent auditor.

Therefore, for this study, dependability was ensured indirectly through the techniques utilized to establish credibility which include prolonged engagement, persistent observation, and member checks.

Confirmability. It can be defined as a process of verification where by one can establish the degree to which the findings of an inquiry are determined by the subjects and the conditions of the inquiry and not by the biases, motivations, interests, or perspectives of the inquirer (Lincoln & Guba, 1985). For the current study, confirmability was established by cross-checking the final themes, conclusions, and analysis with original verbatim transcription of each interview and the field notes comprising of comments, observations, personal reflections, interview summaries, and suggestion made by the participants themselves following the presentation of initial data analysis to them. Also, conformability was ensured by formulating the results in such a manner so that they derived completely from the participants' stories, with minimal interpretations by me.

Results

Donna

Donna is a 54-year-old, Caucasian female. She holds a master's degree in Social Work; she is employed part-time and is mother of one. She is separated from her husband and hopes to be a mental health counselor in the future. Her account of depression is full of particular instances of loss and betrayal but ultimately she portrays herself as a hopeful person. For Donna, experiencing a mental illness like depression has emerged as an important learning experience. She wishes to utilize it to give similar hope to others who also suffer from depression:

> *"I know I have depression and it's recurrent .....I am aware of that but at the same time I am also aware that I have traveled a road and perhaps, and this is my hope.... to let them know, 'you know, yes, you have depression and I have experienced it but you know, (I am) still here and you are still here and there is hope.' There is, even when we think there isn't."*

How depression began for Donna. Donna had a preoccupation with death and dying at an early age of 16. When a teacher at her school brought this to her parent's attention, she was taken to the family doctor. He prescribed her anti-depressant medications for the first time in her life. Within two years she got married and moved to the country to live with her husband. Donna had lived in a big city all her life. She described the difficulties in adjusting to a life in the country and feeling very lonely and sad. According to Donna, although she felt lonely, she does not remember being depressed at that time. But the delivery of her son acted as a final stroke that brought on

the first severe episode of depression. Depressive feelings also included thoughts of ending her life:

> *"... (I was not that depressed) until I became a mother and the year that my son was born. He was born in October and that year after he was born that winter was extremely difficult for me and I remember being suicidal actually at that point....I had decided to be a stay-at-home mother and so the money problems and all of that really started to take a toll on me and I am not sure if it was Post- Partum Depression exactly but I remember thinking I just wanted to die, that things will never change..."*

Loss is one theme that features recurrently and significantly in Donna's narrative. It came in the form of deaths of five loved ones for her. Within a very short period of time, Donna lost her mother, best friend, and even her beloved pet dog. Donna suffered disbelief, shock, and grief as a result of these unexpected deaths. Furthermore, the severe demands to perform multiple roles efficiently were placed upon her at the same time. Donna was required to be a good wife and mother, to work 80 hours a week while also attending graduate school. She identifies these factors as catalysts for the onslaught of a second depressive episode and ultimately her first suicide attempt. Donna decided to stop taking her medication for hypertension. Burn out with lack of social and emotional support to deal with feelings of grief thus became triggers for depression:

> *"...at that point I was on medication for hypertension and I had gotten so depressed I just thought it was stupid to keep fighting this. My husband didn't seem to understand I was working two stressful jobs....trying to continue to maintain a semblance of normalcy for my son*

who was about 13 at the time and....13 or 14... so I was trying to keep all that going and I just kept getting worse and worse and spiraling then I started having health problems with the blood pressure and at one point I decided that I was just going to end it all...."

Donna's experiences of depression. Donna described herself as a 'very visual person'. She used a combination of her ability to visualize vividly and a life long passion for dance to portray depression as 'a very handsome man'. According to Donna this handsome man entices her to dance. If she decides to accept, it would turn into 'a dance of death'. The more detailed and vivid this image of the dance is, the more severe is Donna's depression became:

"...And there is a ballroom and...I can imagine: 'O.k. Clarke Gable is in the building.' Which means I am not in a good place and when I get really really depressed, it's like he enters the ballroom and wants me to dance with him and it's the dance of death....but when he comes into the ballroom it's very very enticing because he is wanting me to dance and it's that when I get, you know, really really bad."

Donna also emphasized how depression can be an 'all-consuming' and completely overwhelming experience. She highlights the times when depression left her feeling like a worthless human engulfed in feelings of 'profound sadness'. This sadness was further coupled with complete lack of motivation and loss of power to change her situation:

"Well, basically for a while it consumed me, you know, and I was just thinking, you know, "How to get out of here? Just get out of here. I'm

worthless" I didn't see things changing at all.... I would have this profound sadness, just really really sadness, with no motivation, whatsoever.... I couldn't see that I had the power to change anything and I just wanted out...."

Donna utilizes the metaphor of 'being filled with concrete' to describe how depression affects her body physically. She describes how when she is depressed, not only her movements but also her thinking slows down. She relates walking with her head down when depressed. She also utilizes these physical events as 'red flags' for an impending episode of depression:

"... for me that feels like someone has poured concrete inside my body and I am moving with concrete limbs and trying to trudge across life, you know.... I find myself bending my head over to walk and I am not walking upright and I know: 'Ooo..Oooo' even though I haven't gotten to the point where I feel my head is filled with concrete and my body, that's still a signal, something is not working."

The price of depression for Donna. Throughout her narrative, Donna talks about the price she has paid over the years for having a mental illness like depression. Sometimes it has come in the form of loss of physical well-being. Donna's only suicide attempt that involved stopping her medication for hypertension resulted in a massive stroke and a number of smaller strokes. The massive stroke resulted in extensive hospitalization, paralysis of the left side of her body, loss of psychomotor and speech skills, and loss of short-term memory.

Depression not only affected Donna's physical self but has also impacted her economically. Her husband filed for bankruptcy and she was forced to do the same to avoid the creditors. This bankruptcy has also resulted in the loss of their home. Donna has now filed for Social Security Income for the first time in her life.

Depression has also significantly impacted Donna's ability to interact fully with others, including her husband, son, and friends. It exerted a significant strain on her marriage since the first severe episode. Donna describes herself as 'defected' (sic) and a woman who no longer looked like a 'vibrant, nice looking lady'. The rejection from her husband, in addition to the realization that she would no longer be a fully functional member of the society precipitated a third severe episode of depression. Every episode of depression in Donna's life is accompanied by increased difficulties in her marriage leading to the ultimate separation from her husband.

Following the stroke and the third episode of depression, Donna lost her status of a 'good wife' as she was no longer able to perform some of the same things that she did effectively before the stroke. The stroke also altered the way she looked. She experienced rejection by her husband as his wife. Similarly, she was no longer able to go to school or work. Thus for Donna, with stroke and depression came loss of power, status, and her 'former self':

> *"I came home to live again and my family....my husband had rejected me....he didn't want me anymore and I didn't understand, he didn't try to work with me or as it was my understanding he didn't try to work with me and make things easier and we still had our business and our home at that time and I was trying to do the things for the business*

that I had always done and I was just not capable of doing that so it was very very difficult to come home and I had lost my former self and my former body is gone and my husband is withdrawing from me...."

How Donna deals with depression. Donna has utilized a gamut of traditional and non-traditional approaches to deal with depression. Her narrative highlights her extensive, long-term relationship with mental health professionals and anti-depressant medications. Donna describes her experiences of counseling and counselors as something that she is 'very, very, impressed' with. She relates her extended, trustworthy relationship with her current therapist as an example of this:

"...honestly if it had not been for Gloria I would not even be here... I feel very comfortable with her and I feel that because we have long extended relationship, I can tell her anything and I know that she has my well being in mind and I know I sign documents and I understand what those documents mean if I would be in any danger then Gloria would make sure that I am safe."

Donna has been taking anti-depressant medications since the age of 16 and she has been forced to take many other medications after the stroke. Medications have been in Donna's life for such a long time now that she describes 'taking a pill' for depression as 'just one more pill'. According to her, anti-depressant medications are something that she feels 'grateful about' as it offers her an additional way to deal with depression with minimal side effects.

Donna also highlights some of the non- traditional means that have been very useful in her battle against depression. She recounts that in the midst of a particularly severe depressive episode or when she has been suicidal she would often set the kitchen timer for two minutes and then would wait for it to go off. This has often helped her to focus on just 'the next two minutes' of her life and not feel overwhelmed by feelings of depression. Following a list of mundane chores like cleaning the house and caring for tomato plants have also acted as agents of generating hope and a sense of purpose:

> *"So I would get the kitchen timer and I would set the timer and say, "O.k. God, I know I can live for two minutes, I know I can do it. Now, I hope I can live through the entire day but I can do two minutes." I had little chores everyday that I tired to do and in the summer time I had tomatoes plants that we planted together and my job was to care for the tomatoes so I would water the plants everyday and fertilize them every two weeks. Just this little chores to keep me....keep me feeling that I had something to live for."*

Donna grew up in a Protestant household and places equal emphasis on the role of church and prayer in her long battle against depression. She describes herself as someone whose mission is to let God's love speak through her and to others. Praying to God, especially while she is anxious and in the midst of depression not only 'grounds' her but also provides her with much needed peace of mind and relief:

> *"I have a...a personal mission statement that I have for myself, that I developed. My personal mission is that 'My higher power is God' and I believe that my mission on earth is to let God's love speak through*

me to other people and that's what I am here for... It seems to give me some peace, some relief and the anxiety....when the anxiety portion of depression kicks in, I can usually pray for somebody else and I feel like I am needed and do something useful with my time, you know, and I really feel that it's important."

Donna's narrative also highlights how finding connections with someone in her life has acted as a very effective means of coping with depression. Donna asserts that connections with people act as a shield whenever she struggles with thoughts of suicide. For example, she mentions more than once, about being there for her son as a reason to keep her from committing suicide. Similarly, she identifies her relationship and commitment with her therapist and with God as significant factors in battling suicide:

"I remember thinking I just wanted to die that things will never change and I just could not do give up for that little boy.... I did, sometime within the last year I thought about....it was just the fleeting thing, I don't even know where it came from, it just looked like....in my mind it looked like I was...like 'Oh, I could just end this all, you know.. today' and then I thought, 'I can't do this. I won't do this. I promised all these people.' So somehow my connection to them seem to help me."

Donna's storyline. Donna's narrative highlights the constantly evolving nature of depression from moment to moment and episode to episode. For her, being depressed started out as a constant but mild preoccupation with death and dying. As a newly married wife and a new comer to a life in a small town depression took the form of homesickness and fear. Motherhood brought with it the most severe form of depression

that Donna had ever experienced. It was so severe that it brought on a sense of profound sadness that she had never experienced before. She came face to face with such hopelessness that ending her life became a likely choice for the first time in her life.

Depression came in the guise of overpowering grief when some of the people Donna loved died within a short period of time. In the absence of support from her husband, it became extremely difficult for her to continue to be a good wife, mother, student, and employer. This time depression came in the form of burnout from juggling these overwhelming responsibilities single handedly. The sense of worthlessness that characterized her depression following the stroke was so profound that it transformed her identity from a 'vibrant nice looking lady' to someone who was perceived as 'defected'(sic). After years of reappearing depression in one form or the other in her life, its meaning has taken a gradual positive turn for Donna. She has found a way to incorporate it not only in her life but also in her identity. Depression has now become one of the most valuable learning experiences of her life. Donna appears to be grateful for experiencing a mental illness like depression. It has made her stronger and more hopeful. She now wishes to share her story with others who suffer from depression and be a guiding light for them:

> *"I think for myself....I still can see myself moving forward. I still have goals as a professional. I still want a private practice to help others. I want to work in the field of bereavement and grief because I have a lot of experience in that field, both, from death and then the loss of my former self and acquired disabilities. There is a lot of grief that comes from that and depression is part of that grief process.... I have experience, I guess,*

that kind of can be beneficial to other people to help them, you know and self-disclosure helps a lot."

Another important feature of Donna's story is her frequent use of professional psychological terms associated with depression and mental illness. Donna utilizes the psychological term 'Seasonal Affective Disorder' to describe the feelings of sadness she oftentimes experienced during winter. She questions if the severe depression she experienced following the birth of her son was Post- Partum Depression. She also mentions Cognitive Behavioral Therapy or CBT as one of the more useful approaches of therapy that her current therapist uses. These frequent uses of psychological terms in Donna's narrative seem to indicate that Donna has come to accept the medical or the psychological explanation for depression. Her educational background of Social Work is also likely to be an important factor for accepting depression a psychological illness.

Thus, Donna's story or narrative ultimately emerges as a story of hope and one that ends in triumph. The acceptance of depression as an ailment or a disease might be an important milestone on this journey of triumph. Donna's story also appears to be what Frank (1998) describes as a 'quest story': A story of illness where the illness becomes a condition from which something can be learned, and this learning can be passed on to others. Frank asserts that quest stories are about illness leading to insights and they are based on a claim that the ill person now sees a depth that illness has made visible (1998). Donna battled depression all her life but now she is grateful that she experienced it. She indirectly credits it with providing her with some invaluable insights into meaning of suffering and pain. Donna wishes to be a grief counselor. This ambition also partly germinates from her experiences of depression. She now hopes to use the insights she has

acquired from suffering depression to help others. She has reclaimed her life by giving a new meaning to depression and in the process has come to create a 'new self', one of a 'helper'.

Donna's story also ascends towards the present moment in her life. It is evident from the structure of her narrative. The story progresses from Donna's earliest experiences of depression to the present moment in her life:

> *"I am also aware that I have traveled a road and perhaps, and this is my hope, (I) can help them to avoid some of the bumps on the road and also to let them know that 'you know, yes, you have depression and I have experienced it but you know, still here and you are still here and there is hope.' There is, even when we think there isn't. What if I didn't, I would have never finished the degree or I would have never been a mother, you know all these little perks that we have to our...to look at and hopefully my story will help somebody else. Give them hope and say, 'You know, that lady did,' and maybe that would help them."*

Tony

The second participant in my research is Tony. He is a 46-year-old Caucasian male, self-employed, currently divorced, and father of four. He has a master's degree in Business Administration. He has been sober for the past 11 years and has experienced depression since he was 16. Unlike Donna who comes across as a hopeful person and who perceives depression as a learning experience, Tony is confused, at times angry, and extremely skeptical about living a life completely devoid of depression:

> *"I have had to admit I have lost the ability to imagine what life would be like without depression. I just can't imagine it. I can't. Even when I try and sit down and dream up pleasant thoughts....I can't even dream up how it would feel to not have to battle this. I have lost....just lost that ability and that's why I don't look into future because every time I do I see depression."*

How depression began for Tony. Tony very briefly describes his negative relationship with his father early in his childhood and also how that could have left a permanent mark on his subconscious. Tony insists that he has always been very weary of authority figures in his life. He attributes this to the negative relationship with his father. He entertains the idea that some of his early experiences of depression and addictive behaviors are likely to be related to the way his subconscious influenced and continues to influence his moods, reactions, and interactions with other people:

> *"...the fact that my subconscious had influenced.....my moods, my reactions and interaction with people.... I can be influenced by my own subconscious and that a lot of these things were rooted in very early childhood experiences...some negative experiences... I am very weary of someone who has authority over me, for a great deal in my life, I have been treated pretty poorly by people in authority, primarily my father and through that I have...a great deal of suspicion for someone who has authority over me."*

Despite struggling with addiction and depression from an early age, later in his life Tony took charge of his father's business with his brother and became a very

successful businessman. He compares his business to being 'the Lamborghini' of the car industry in his field. At that point in his life, he was not only traveling all over the world as a successful businessman but was also happily married to his second wife. The unexpected decision by his father to sell the business without consulting Tony or his brother and the simultaneous announcement by his wife that she was leaving him propelled him into severe depression. Tony felt betrayed and became hopeless to such an extent that he went through a couple of years of little or no activity. He kept himself in his house, spoke to nobody, and did nothing until he was forced to get help by his family:

> *"That business got sold very suddenly and with some deception by my father and I was left with no chance to buy it and that was really for me when things started to feel like they were just hopeless.... I'll never forget....that was really the point when things started to really go downhill for me...it was...that's when the hopelessness started to creep on me....and the evaporation of my second marriage which I had been in only for two years, it was kind of like the icing on the cake, I just...I just felt like there really wasn't gonna be any happy ending to my story...."*

Tony's experiences of depression. Throughout his narrative Tony emphasizes how it is extremely difficult for him to convey to others what it feels to be like and why he becomes depressed. Like Donna. Tony uses metaphors to convey his feelings of depression. For Tony being depressed meant being bewildered, helpless, and feeling physically ill. It is equivalent to being "cast to the wind". It is as if there are "little pieces of him that are falling apart and there would never be enough piece to put him back together":

"I can remember being so bewildered and feeling like there is little pieces of me falling off all over the place...and they were never gonna find enough of those pieces to put me back together.... helpless is the only word that can come up with but it doesn't describe the feeling so...it was like I was cast to the wind..."

Tony relates that people who have never experienced depression frequently demand to compare depression to a disease or a physical ailment. But with the lack of an objective, definitive proof of a disease like an X-ray, a CAT scan, or a tumor, Tony finds the analogy to a physical disease to be frustrating:

"....if I could...say I have cancer and here, here and here (pointing to body parts), I have diabetes and I have to take insulin and test my blood sugar and I...people encourage those of us who are afflicted to look at with mental illnesses just as illness but it's pretty damn difficult (raise voice slightly) to do that.... I can't take an X-ray and identify, I can't take a CAT scan and identify, I can't take a caliper and measure a tumor and see what has grown or shrunk...."

Tony struggles with the meaning of depression. He asserts that people who don't have a firsthand experience of depression characterize it as 'slacking off' or 'unwillingness to try hard enough'. He also sometimes feels that he is just 'being lazy' or is 'lacking in moral fiber'. He questions his capabilities when he says that he has a tendency to feel like a personal failure rather than feeling that he has an illness:

"My tendency is to think....to think in a just lacking in moral fiber or 'I guess I just don't have enough horse power under the hood'...."

Tony claims that one of the most debilitating effects of depression experience is its capacity to rob him off of the pleasure of everyday life. Experiencing depression means not knowing if he would be able to enjoy, for example, "eating blue cheese on crackers". He explains how when he is depressed he is unable to enjoy the beauty and simplicity of life from one day to the next. It impedes his ability to accomplish even the most mundane activities of daily survival. Depression takes away the 'sparkle in life':

"(I) came from there to a point where it's extremely difficult for me even to go through my mail...a lot of times, it's not unusual for me to go months without going through my mail. I have paid my credit card bills over the phone, utility bills over the phone, even as far as going to the post office is or going to the grocery store is a....damn challenge. I have been out of food to the point where I have eaten peanut butter and jelly three meals a day, can't stand it anymore before I would go the grocery store somehow the whole experience is unnerving..."

The price of depression for Tony. Throughout his narrative, Tony tries to grapple with the price he has paid for experiencing a mental illness like depression. Although depression has taken a toll on every aspect of Tony's life, he argues that it is the area of relationships that has been affected the most. Depression has affected his relationship with his two wives, parents, siblings, friends, and employers. But the impact of depression on his relationship with his four children, especially with his youngest daughter stands out in his narration. Tony explains that depression inhibits his ability to

communicate verbally and nonverbally with others. When this occurs with his daughter, she interprets it as absence of love and apathy towards her. Tony talks about how he was unable to see his daughter for more than three months, let alone talk to her during a particularly severe period of depression. Similarly, Tony explains with increased frustration that depression blocks him expressing his emotions in a way that could be understood by people he loves. Time and again, family and friends have given up on him after trying everything they know to understand what is happening to him. According to Tony, when depression strikes, 'relationships die':

> *"....not too many relationships that I can point to haven't been affected or ruined. Children, obviously two wives, my brothers, my sisters, employers....my youngest daughter, I didn't even talk to her for three months, much less see her. I got so down and I just withdrew from everybody and everything. You know, for her...the way that she interprets that, as most kids would and maybe adults is that 'Dad doesn't love me', you know, 'What did I do wrong?'.... so depression inhibits my verbal and nonverbal communicative abilities. Relationships die....You lose friends, you even lose family members who, you know...give up...."*

Tony reflects on how depression has forced him to question the very competence and ability to function as a productive member of the society. He came from being the vice president of a thriving 87 million dollar business, supervising 560 people, and traveling around the world, to not being able to even open his mail or read the headlines of a newspaper. When he returned from the Menniger clinic after receiving extensive treatment for depression, he was not even sure if he would be able to work in any job

except in a very menial capacity. Tony highlights how depression has taken away his ability to perform many of the things that gave him pleasure and sustained him physically and financially. Over the years, Tony has come to question his ability to judge people accurately. He emphasizes that depression has indirectly contributed to this, as he does not trust his perception of reality, especially in the light of lost relationships and employment:

> *"I came out of Menniger and... not knowing whether I was going to be able to work....or whether anybody will hire me.... I came from a white collar executive employment level as a vice-president of a business that was 87 million dollar when we sold it, 560 people were performing, I was charged with and executing high level of responsibility, traveling internationally, came from there to a point where it's extremely difficult for me even to go through my mail... you know, it's hard to admit the toll....the pay, the point that I am at, it's hard to admit that I have...I have lost capability...."*

Stigma that usually accompanies labels has also haunted Tony all his life. First he was 'an addict' then he became a 'recovering alcoholic'. But according to Tony, experiencing depression has meant that now he has turned into a 'crazy alcoholic'. Although, Tony is aware that a significant number of people he knew who struggled with alcoholism also suffered from depression like him, he is forced to cope with one more label in his life:

> *"I was...when I was first told that (I have depression) when I was two years sober, I think and I thought, "Son of a bitch, you know, it's not enough that I am an alcoholic. Now I am a crazy alcoholic. I got to deal with this on top of everything else."*

How Tony deals with depression. Over the years Tony has tried to come to terms with depression and the toll it has taken on his life. Just like Donna, his efforts to do so run a gamut of traditional and alternative means. Tony spends considerable time discussing his experiences with anti-depressant medications and psychotherapy. Tony's first serious encounter with anti-depressants began almost eight to nine years ago following his participation in the 12-step AA program. Since then Tony has been on every kind of SSRIs, Nor-epinephrine reuptake inhibitors, and many other kinds of anti-depressants. Currently, he is on Paxil. Tony considers these medications as a vital ingredient in combination with other measures in a continual battle against depression. At the same time he describes this experience as being on a 'pharmaceutical merry-go-round'. He feels that he would never be able to get off of it.

Tony explains how every trial of a new medication involved an extremely long and painful period of first tapering off the old medication, starting the new medication, and then waiting for weeks for the effects of the new medication to start. This usually meant going without any medication for a considerable period of time while in the midst of a depressive episode. Tony equates this experience to 'being in hell'. These previous, mostly trial and error experiences of anti-depressants, have also forced Tony to question the validity of the science involved in them:

"I think it's a vital ingredient, I think it has to be coupled with other things, at least for me it's had to be coupled with other things....every time you go through trial and error you got to take time to go off of the old drug, taper off of it, start into the new drug and wait a couple of months for it to go and all this time, you know you are not receiving the benefits of the medication, it's hell....God help me if I ever have to change the medicine again, my experience with that has been frightening. It's treatment is that you are on a pharmaceutical marry-go-round that you can't seem to ever get off...."

As Tony's narrative progresses, it becomes apparent that following an initial period of suspicion and disenchantment he has tried to integrate the medical reality of anti-depressant medications into his understanding of depression. Tony has invariably come to accept the medical version of what is wrong with him and what to do about it. This becomes evident when Tony equates taking a pill daily for depression to having a physical disease like diabetes and taking insulin everyday. Furthermore, Tony compares himself to hundreds of other Americans who are likely to be on all kinds of prescription medications for many different varieties of ailments:

"....it bothered me that I was having to take a pill to regulate my mental health but you know, as I started to understand that it was an illness and one doctor asked me, he said, "If I told you had diabetes would you argue with me about taking insulin?" I said, "Yeha, probably but not as much." I wouldn't argue as much, "No". I take the med. I mean, I think if you would pick out 100 average Americans households and look into

their medicine cabinets you're gonna see people on all kinds of prescriptions. So I am just another one of those."

Tony's extensive experiences with counseling and mental health professionals parallel his experience of anti-depressant medications. Tony's first encounter with mental health professionals was when he participated in the 12-step AA program. He credits this program for terminating his alcohol and drug addiction. Yet as the feelings of depression persisted after being sober, Tony continued to receive therapy from various metal health professionals. Tony describes these experiences negatively. For Tony if being on different types of anti-depressant medication was like 'being on a pharmaceutical merry-go-round' then these initial therapeutic encounters was like 'picking at wounds that might have partially healed'. Just as Tony had expressed his doubts about the validity of the science involved in anti- depressant medication, he explains that the area of mental health, unfortunately attracts those who themselves are likely to suffer from a mental illness. His antagonism and distrust towards some of the mental health professionals that he has encountered earlier in his life becomes apparent when he describes them as 'nuts':

"Not something that you would do for fun, not something I would do for fun. I would rather have teeth pulled than do it, I mean it's....I think.....it's not fun, it's lot of picking at...picking at wounds that may have partially healed....there were a lot of cooks in the business...there is, in my opinion. I think, it's a...it's a profession that attracts a...people who either are suffering or have suffered some mental illness. Some of them I know, I would put them in that category, they're nuts..."

Following a recent particularly severe period of depression, Tony's family suggested that he should go to the Menniger clinic for help. Menniger clinic offers in- and out-patient therapy to people who experience different kinds of mental illnesses. Tony described this recent, extensive four months in-patient therapeutic experience as the most beneficial of all prior therapy experiences. According to Tony, unlike previous therapists, his therapist at the Menniger clinic was 'the most amazing person' he had ever met. Tony explains that a breakthrough came when this therapist enabled him to piece together the relationship between some of his negative childhood experiences, its impact on his subconscious, and how his subconscious could influence the experiences of depression. After the initial suspicion and disenchantment with mental health professionals, this experience has been instrumental in restoring Tony's trust in mental health professionals. Currently, Tony receives individual therapy. Although he experiences occasional doubt in the purpose of therapy, he also finds it enlightening:

> *"I think it (counseling)....it helped me learn something about myself.....I think it...it...it helped me learn some things about myself and helped me realize some of the reasons that I am the way I am...it did give me some tools for dealing with it. The reason I am in Tai Chi and study Tai Chi is...is because of this doctor who was my personal doctor at Menniger.... I go through times where, you know, Dr. L. where I feel like it's enlightening and then I go through other times where I just feel like I am just kinda going through the motions, you know, where I feel like I am not really deriving any measure of benefit from it...."*

Tony mentions Tai-chi as one of the alternative means that helped him cope with depression. It is one of the more enduring benefits of Tony's therapeutic encounter at Menniger clinic. He explains that he was introduced to the benefits of Ta-chi by the doctor who worked with him. Tony calls it 'mind boxing', something that he could even do in his head, when his body refuses to commit. He relates that practicing Tai-chi helps him when he is in great deal of physical or emotional pain.

> *"When I got out of Menniger...start practicing Tai Chi and if I am in a great deal of emotional pain or physical pain...a....that's one of my better coping mechanisms, there are some techniques that...it's....it's more of a physical, spiritual art than it is...you get a lot of benefits out of it..it's...guy I know that's a master at it, calls it 'mind boxing', Something you can even do in your head when your body won't commit. So that's a coping mechanism."*

Tony also highlights the relationship between spirituality and depression in his life. He draws attention to the importance and continual presence of a 'Higher Being' or God. Tony credits God with helping him to learn from some of the most painful experiences of his life like addiction and depression. According to him, with the help of God, he has traveled a road to come to a place where he is able to return the favor and help others by acting as their sponsor:

> *"it (12-step program) helped me..a...build a stronger faith in God because God did some things for me that....He helped me.... help me learn from some painful experiences the things that I needed to learn and also put me in a position where I could talk to other people who were in similar*

situations and talk to them about my experience and...and be credible. I talk to God all the time, during my work day and....all the time. One of the last things I do before I close my eyes at night is talk to Him about my day and how can I look at my day and see where...where it went wrong."

Although, almost all close relationships in Tony's life have either suffered or have been lost due to his continual struggle with depression, the relationship with his mother has been an exception. This relationship has not only remained a constant in Tony's life but has also proved to be a tremendous source of love and caring. Tony has learned to forgive himself and others from his mother's willingness to forgive and pardon his mistakes:

"She (my mother)....she has taught me, among other things.....the power of forgiveness and what a vile thing it is.... she has a, I think a....willingness to accept that people, even her own kids are gonna make mistakes which she wouldn't have made and didn't make but... a....a...she could look past that and still love us. That's a pretty powerful thing. I just know she loves me, you know. There is no question in my mind that she loves me. That's a...that's something."

Tony's storyline. Just like Donna, depression has acquired different meanings at different times in Tony's life. As an adolescent, Tony felt a profound absence of fulfillment in his experiences. At that time he did not see such experiences as 'depression'. It just felt as if 'something was not right'. Later, Tony tried to masquerade the feelings of depression with a long addiction of alcohol and drugs. He also questioned if his early depressive experiences were a product of alcohol and drug use. As Tony

became sober, the feelings of depression became acute and pronounced in the absence of alcohol and drugs. Now for the first time in his life, they took on the form of a mental illness that was officially diagnosed as 'clinical depression'. Tony was forced to recognize that these feelings of depression were different from the mild persistent feelings of being sad or a lack of fulfillment that he had experienced earlier in his life. Tony's efforts to understand depression as a 'tangible enemy' like addiction and a physiological disease like cancer or diabetes has failed consistently. Tony has also questioned if depression could be related to the way his subconscious exerts control over his moods, behaviors, and interactions with others.

Taking an anti-depressant medication has forced Tony to at least partially accept the biochemical meaning of depression although he is still extremely skeptical of the science behind it. What it feels and means to be depressed has evolved and continues to evolve for Tony. Depression for him is feeling being broken and hopeless; it is personal failure and being morally weak to face the daily trials and tribulations of life and unfortunately it is also the only constant in his life.

Unlike Donna's story which emerges as a story of hope, Tony's story appears to be a tragedy. He is still struggling to find what it means to have this mental illness called depression. He is unable to imagine a life that is devoid of depression and his constant efforts to battle it. If Donna has found a way to see depression as a life changing experience, Tony is still contemplating a proper place of depression in his life. Donna is able to envision her future as a counselor whereas the very thought of future is scary for Tony. In fact, he argues that he has lost the very ability to do so:

"....I have had to admit I have lost the ability to imagine what life would be like without depression. I just can't imagine it. I can't. Even when I try and sit down and dream up pleasant thoughts....I can't even dream up how it would feel to not have to battle this. I have lost....just lost that ability and that's why I don't look into future because every time I do I see depression."

Donna's story of depression is that of hope and optimism and is a 'quest story' where as Tony's story is more of resignation and pessimism. Tony's story can be characterized as what Frank calls a 'chaos story' (1998). According to Frank, in a 'chaos story' the ill person does not see an end to his or her illness. For her or him the pain will never remit and there is a chance that the disability would increase as a result of continual illness (1998). This becomes apparent towards the end of Tony's story when he talks about his inability to envision his life without depression. Chaos stories also elicit strong responses in the listener. Whenever I listened or read Tony's story, it evoked a kind of uneasiness in me. I felt as if I was being sucked into a whirlpool of struggle and sadness that I wanted to get away from as soon as possible. The sense of resolution that I felt at the end of listening to Donna's story was completely absent when Tony had finished telling his story. Tony's narrative seems to permeate with a sense of chaos especially in his ongoing struggle to interpret the meaning of depression in his life.

Furthermore, chaos stories are full of 'and then' constructions whether literal or implied as the narrator seems to move from one problem to another. Tony struggled with addiction and depression from an early age (and then) the successful business that he had built on his own got sold without his knowledge (and then) there was the sudden

dissolution of his second marriage. Sobriety did not bring any respite from feelings of depression. (And then) a series of failed encounters with number of mental health professionals and anti-depressants left him dissatisfied, angry, and severely depressed. Although Menniger clinic provided Tony with a new understanding of the workings of his subconscious and its likely relation with depression, ultimately he presents it only as a temporary respite. (And then) In the end he feels that he has lost the ability to trust and judge people accurately as he has no control over his subconscious instincts or drives:

> *"....at Menniger having to realize how much I can and am driven at times by subconscious.... I don't always...I don't always trust myself. I doubt myself today more than I ever have. I ask myself if I am...I am feeling myself getting angry, 'What are you angry about? Should you really be angry?' I don't trust other people to a degree that I once trusted them.... I don't trust my perception of reality, I wonder you know, everyday of my life if I am looking at things correctly or there is some part of the subconscious thing that's, you know causing me problems and that's....a....causing me to form incorrect conclusions or react improperly."*

Tony's story can also be seen as a 'restitution story' where by he has partially come to accept the sick role. This is apparent in the gradual change that has occurred in Tony's view about medication and mental health professionals. He devotes a considerable time discussing his experiences at the Menniger clinic (space allotted to this discussion) and the role of the subconscious (the amount of space allotted to that discussion, and the way that day at the Menniger, and the therapist are described).

Unlike Donna's story, Tony's story descends rather than ascends towards the present moment in his life from a more positive moments and situations. For example, from having a white collar executive position, being married with kids, possessing excellent mathematical and statistical skills, and a desire to succeed to an inability to even finish routine tasks, being single, loss of capability and loss of a desire to succeed.

Discussion

In traditional research, depression is conceived of as a 'disease' situated within an individual. It is either present or absent (either in remission or recurring) to a mild, moderate, or severe degree. Depression becomes a single, tangible, and fragmentable 'entity' fixed in time that can be measured and controlled. The experience of depression gets reified, interpellated, and the individual suffering inherent in an illness like depression is lost.

In the present study, depression was examined through the subjective approach of narratives. Depression was conceptualized as an 'illness experience' or 'illness narrative'. The experiences of depression for the two participants in the present study were dynamic, constantly evolving, multidimensional and holistic in nature. Participants used what Kangas calls the process of 'narrative reconstruction' to depict depression as an 'illness experience' (2001). It is the process where the biographical interruption posed by illness is woven into the cloth of the individual's life by an active search for meaning of the illness. It is an ongoing and continuous process where new meanings are found and old meanings replaced, making the illness narrative a storytelling with no end, and is thus difficult to comprehend solely from a singular perspective (Good, 1995 as cited in Kangas, 2001).

Explaining Depression from Multiple Sources

The participants in the study used many individual, social, and cultural sources to make sense of depression and to answer the question 'why me' at different times in their lives. They referred to individual personal events like negative childhood experiences and loss of loved ones to account for depression. The burn out often experienced by women as a result of excessive demands and the absence of much social support featured as a social context for Donna's sense-making process. The profusion of psychological terms in Donna's narratives and partial acceptance of anti-depressant medications in Tony's indicate the acceptance current culturally popular psychiatric and psychological explanations for depression. Rather than relying on any single etiological explanation, the participants used bits and pieces from all of three sources of explanation to construct their understanding of depression.

The Central Experience of Suffering and its Metaphors

The participants used metaphors to describe their experiences of depression. Metaphors captured the overarching suffering central to an illness like depression. They also served as an important vehicle to convey to those who have never experienced depression what it means to be depressed. Depression is more than just the traditionally identified clinical symptoms of 'sadness, lack of energy, feelings of helplessness, and recurrent thoughts of death present during the same two-week period'. The term 'psychomotor retardation' even fails to sufficiently capture the pain and suffering that is conveyed by metaphors like 'it feels as if I am being filled with concrete' or 'I am being cast to the wind'. For the participants, depression could be as simple as the inability to 'enjoy blue cheese on crackers' or could be as severe as 'the dance of death'. Metaphors

communicate the suffering that impinge not only upon one's body and mind but also upon one's sense of self and identity. The present study highlights the suffering that is intrinsic to an illness like depression. Suffering is not simply an unverifiable premise that underlies an observable response. It is central to the experience of depression itself.

The Evolving Self and Experience of Depression

People who suffer from depression are at different points in the evolution of their 'depression career' (Karp, 1996). While Donna was successful in constructing a new self that will "work" better for her, Tony appears to be still harboring the thought that his life would never be completely devoid of depression. According to Karp, much of the depression career is caught up with assessing self, redefining self, re-interpreting past selves, and attempting to construct a future self that will "work" better (1996, chap. 3). People who suffer from depression are constantly involved in charting the difficult terrain of evolving identities. Donna has come to successfully incorporate depression into her life, reinterpreting its meaning as a useful experience. Tony, on the other hand, appears to be still redefining his self in the light of what it means to suffer a mental illness like depression.

Gaining a Voice in Depression

The present study highlights how a subjective approach to studying depression enables the participants to construct their own stories in which depression emerges not as a disease but as an 'illness experience'. No standardized interview schedules or questionnaires for depression were utilized to either recruit or categorize the participants. Similarly, no prior criteria about participants' age, ethnicity, socioeconomic-background, or educational level were utilized. The requirements for participation were limited to a

diagnosis of Major Depressive Disorder and a willingness to share their stories of depression. Although a semi-structured interview schedule was developed, for the most part the interviews were not directed by a list of questions or topics, but focused instead on the issues brought up by the participants. Most importantly, first and foremost being just a witness to the stories presented allowed the participants to construct the narratives of depression on their own terms.

In the more traditional approach, depression is often times conceptualized from the researcher's point of view (i.e., the DSM criteria for depression). In contrast, the present study encouraged the participants to present their 'illness narratives' or stories of depression, providing them with an opportunity to gain a voice. The aim of the current research was to witness the sense-making process of depression from the participant's point of view. Therefore, emphasis was on listening to what it meant for the participants to suffer from depression. The very opportunity to present their story of depression allowed the participants to put forward their own likely explanations for depression. Participants portrayed themselves as victims, sometimes of excessive demands placed upon them and at other times of negative childhood experiences. Narration also became an occasion for the participants to reflect upon the inappropriateness and the futility of comparing mental illnesses like depression to physical ailments like cancer or diabetes. Thus, presenting their own story of depression allowed participants to defend against the threat of being defined as less than competent or capable.

The Contextual Nature of Depression

One of the consequences of an objectivist and diagnostic approach to depression is that information about a depressed person's life circumstances and everyday activities

get stripped away as unnecessary detail. This often occurs in a process that "decontextualizes" and reduces people's experiences. The results of this research highlight how retaining all the personal details of the participant's depression experience enabled conceptualization of depression not only as individual suffering resulting in individual changes, but also as embedded in relationships and social settings.

Karp asserts that people who experience depression greatly desire connection while they are simultaneously deprived of the ability to realize it (1996). Participants seem to embody this inherent paradox of depression whereby much of the pain of depression arises out of the recognition that what might make them feel better -- human connection and relationships -- seem impossible in the midst of a paralyzing episode of depression. For the participants in this study the experiences of depression invariably became more profound whenever important social connections, whether in the form of death or divorce, were severed.

The stories also highlighted that more often than not it is in the details of the everyday activities like finishing the household chores, tending the tomato plants, or simply praying at the end of the day that sufferers are able to cope with depression. Paying attention to these seemingly unnecessary details of everyday lives are important along with psychotherapy and anti-depressant medications. Thus depression is an illness that is deeply rooted in people's daily social and structural environments.

The Cultural Demands Entailed in Depression

The study further highlights the questions of power, ideologies and practices of the culture of the participants. The participants feel forced to compare depression to cancer or diabetes but at the same time find it increasingly ineffectual in understanding

experiences of depression. On the other hand, the present study shows how the willingness of present American culture to consider medications or 'pills' as the quick and definite means of resolving suffering has enabled participants to normalize the need to take a pill everyday for depression. The experience of depression itself is linked to the overemphasis placed on being and remaining functional, effective, and productive members of the society in American culture. Donna spoke eloquently about the consequences of her stroke while Tony lamented about a job loss.

Conclusion

The findings of this study have theoretical and practical implications. Mainstream approaches within psychology and psychiatry have neglected to look at the meanings of depression for the person experiencing it. Depression is a different experience for everybody, and individuals are actively engaged in interpreting and making sense of depression. Explaining and understanding depression must include looking at the meaning of subjective experiences and this may well imply a revision of the concept of depression.

The continuously evolving meanings of depression and the way it calls upon a revision of a client's identity could provide invaluable insights for treatment. Similarly, paying attention to the more minute everyday details of the client's experiences of depression can help clinicians to generate more novel and innovative ways of coping with depression for a particular client. Finally, listening to a client's story of depression can be the first step towards establishing a more empathic working relationship between the clinician and the client.

The present study also illuminates future areas of research. Further research might focus on the process by which the identity of a person experiencing depression evolves in the context of accepting the cultural definitions of illness like depression. Similarly, research focusing on the way meanings of depression are constructed might suggest ways of revising some of the standardized instruments like SCID-II and BDI-II. For future research, it also entails looking at how clinicians themselves understand the concept of depression, and how far this is consistent with their clients' understanding of their own experiences.

In conclusion, the present study has been instrumental in challenging some of the myths about depression, foremost among which is a belief that depression could be best understood by the 'professionals in the field'. This study provided me with the opportunity to develop a newfound respect for the people who experience a debilitating illness like depression and the insights they possess about their illness. For a novice researcher and a clinician, the result of the present study elucidates the importance of always remaining grounded in my participants' or clients' point of view.

References

American Psychiatrist Association. (1994). *Diagnostic and statistical manual of mental disorders (4th ed)*. Washington, DC: Author.

Althusser, L. (1984). *Essays on ideology*. London: Verso.

Beck, A. T., Steer, R.A., & Brown, G. K. (1996). *Manual for the BDI-II*. San Antonio, TX: Psychological Corporation.

Coffey, A., & Atkinson, P. (1996). *Making sense of qualitative data: Complementary research strategies*. Thousand Oaks, CA: Sage Publications.

Danquah, M. N. (1998). *Willow weep for me: A black woman's journey through depression*. New York, NY: W. W. Norton & Company.

Denzin, N. K. (1989). *Interpretive biography*. Newbury Park, CA; Sage Publications.

Drew, M. L., Dobson, K.S., & Stam, H.J. (1999). The negative self-concept in clinical depression: A discourse analysis. *Canadian Psychology, 40*, 192-204.

Drew, S. (2003). Self-construction and biographical revisioning: Survival following cancer in childhood or adolescence. *Health: An Interdisciplinary Journal for the Social Study of Health, Illness, and Medicine*, 7, 181-199.

Endler, N. S. (1982). *Holiday of darkness: A psychologist's personal journey out of depression.* New York, NY: Wiley.

First, M. B., Spitzer, R. L., Gibbon, M., & Williams, J. B. (1997). *User's guide for the Structure Clinical Interview for DSM-IV Axis I Disorders*. Washington, DC: American Psychiatrist Press.

Frank, A. W. (1992). The pedagogy of suffering: Moral dimensions of psychological therapy and research with the ill. *Theory and Psychology, 2*, 467-485.

Frank, A. W. (1997). Enacting illness stories: When, what, and why. In H.L. Nelson (Ed.), *Stories and their limits: Narrative approaches to bioethics* (pp. 31-49). New York: Routledge.

Frank, A. W. (1998). Just listening: Narrative and deep illness. *Families, Systems, and Health, 16*, 197-212.

Gotlib, I. H., & Hammen, C. L. (Eds.), (2002). *Handbook of depression*. New York, NY: Guilford Press.

Hamilton, M. (1960). Development of a rating scale for depression. *Journal of Neurology, Neurosurgery and Psychiatry, 23*, 56-62.

Kangas, I. (2001). Making sense of depression: Perceptions of melancholia in lay narratives. *Health, 5*, 76-92.

Karp, D. A. (1996). *Speaking of sadness: Depression, disconnection, and the meanings of illness*. New York, NY: Oxford University Press.

Kendler, K. S., Neale, M. C., Kessler, R. C., Heath, A. C., & Eaves, L. J. (1993). A longitudinal twin study of personality and major depression in women. *Archives of General Psychiatry, 50*, 853-862.

Kleinman, A., & Seeman, D. (2000). Personal experience of illness. In G. L. Albrecht, R. Fitzpatrick, & S. C. Scrimshaw (Eds.), *Handbook of social studies in health and medicine* (pp. 230-242). London: Sage Publications.

Lewis, S.E. (1995). A search for meaning: Making sense of depression. *Journal of Mental Health, 4*, 369-372.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Beverly Hills, CA: Sage Publications, Inc.

Mairs, N. (1986). *Plaintext essays*. Tuscon: University of Arizona Press.

Mays, J. B. (1995). *In the jaws of the black dogs: A memoir of depression*. New York, NY: Harper Collins Publishers.

Muller, J. H. (1999). Narrative approaches to qualitative research in primary care. In B. F. Crabtree & W. L. Miller (Eds.), *Doing qualitative research* (2nd ed., pp. 221-238). Thousand Oaks, California: Sage Publications.

Munoz, R.F., Huynh-Nhu, L., Clarke, G., & Jaycox, L. (2002). Preventing the onset of Major Depression. In I. H. Gotlib & C. l. Hammen (Eds.), *Handbook of depression* (pp. 343- 359). New York, NY: Guilford Press.

Ortiz-Torres, B., Williams, S. P., & Ehrhardt, A. A. (2003). Urban women's gender scripts: Implications for HIV prevention. *Culture, Health, and Sexuality, 5*, 1-17.

Plath, S. (1971). *The bell jar*. London: Harper & Row Publishers, Inc.

Reissman, C. K. (1993). *Narrative analysis*. Newbury Park, CA: Sage Publication.

Robins, L.N., Helzer, J. E., Croughan, J. L., & Ratcliff, K. S. (1981). National Institute of Mental Health Diagnostic Interview Schedule: Its History, characteristics, and validity. *Archives of General Psychiatry, 38*, 381-389.

Stoppard, J.M. (2000). *Understanding depression: Feminist social constructionist approaches*. London: Routledge.

Stoppard, J.M., & McMullen, L. M. (Eds.). (2003). *Situating sadness: Women and depression in social context*. New York, NY: New York University Press.

Styron, W. (1990). *Darkness visible: A memoir of madness*. New York: Random House, Inc.

Titon, J. T. (1980). The life story. *Journal of American Folklore, 93*, 276-292.

Weissman, M. M., Bruce, M. L., Leaf, P. J., Florio, L. P., Holzer, C. III. (1991). Affective disorders. In L. N. Robins & D. A. Reiger (Eds.), *Psychiatric disorders in America* (pp. 53-80). New York, NY: Free Press.

Williams, G. (1984). The genesis of chronic illness: Narrative re-construction. *Sociology of Health and Illness, 6*, 175-200.

Wurtzel, E. (1994). *Prozac nation*. Boston, MA: Houghton Mifflin Press.